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ABSTRACT

This monograph, the product of a symposium about the provision of services to children of alcoholics, contains chapters concentrating on identification, intervention, treatment, and prevention. These concepts are delineated in terms of the needs of children of alcoholics, with a particular emphasis on barriers that inhibit the therapy process and appropriate prevention activities. Recommendations by symposium participants are included in each chapter. Appendix A contains the four symposium papers focusing on the identification of children of alcoholics, intervention approaches, and treatment and prevention issues. Appendix B consists of nine program descriptions outlining program goals and surveying various treatment approaches. (RC)

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Research Monograph No. 4

SERVICES FOR CHILDREN OF ALCOHOLICS

Symposium
September 24-26, 1979
Silver Spring, Maryland

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The opinions expressed herein are those of the symposium participants and do not necessarily reflect the official position of the National Institute on Alcohol Abuse and Alcoholism; Alcohol, Drug Abuse, and Mental Health Administration; Public Health Service; or Department of Health and Human Services.

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Foreword

This monograph is the product of a symposium sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in September 1979. It is hoped that this monograph will serve as one step leading to increased awareness of the issues and needs of one of our most neglected populations: children from homes with alcoholism.

The purpose of the symposium was to invite a representative sample of professionals in the field to share their experiences and insights in this area with NIAAA, to identify critical policy issues, and to assess future needs. While recommendations from the symposium participants documented in this monograph are currently under consideration by NIAAA, we hope that they also will stimulate the thinking and the involvement of others.

The contributors to this document were invited to express their views and opinions freely. The statements contained herein should not be construed as representing the policies or views of NIAAA or other organizations or institutions with which the participants may be affiliated.

We hope that the symposium and this monograph represent the initiation of a continuing and expanding dialog among all of us in public, voluntary, and private sectors whose activities contribute to the health and well being of these children.

John R. DeLuca, Director
National Institute on Alcohol Abuse
and Alcoholism

Patricia A. O' Gorman, Ph.D.
Director, Division of Prevention
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Preface

Children with an alcoholic parent traditionally have not received services that their well-documented needs would demand. Such needs are categorized in three ways:

1. Current research findings indicate that this population is at a greater risk for alcoholism as adults than any other population identified to date. Although the specific cause or causes of this increased risk have not yet been clearly established (researchers disagree as to whether origins are genetic, social, environmental, or a combination of those factors), intervention of a preventive nature at an early age clearly is warranted regardless of the etiology.
2. All family members living in a household where alcoholism is present become involved in the family process or dynamics. If any member's behavior changes, it can affect the entire system and often can be an important factor in effecting the recovery of the alcoholic member. Thus children in such families should be helped to understand the family dynamics they are experiencing and to recognize their own role in that process.
3. Children have few internal or external resources to aid them in coping with parental drinking behavior in ways that do not impede their healthy emotional development. The lack of family stability, the inadequate or inappropriate role model displayed by the alcoholic parent, the unpredictable behavior of that parent, the fear of stigma that adversely affects healthy peer and other interpersonal relationships, the often frequent incidents of family violence, together with the emotional deprivation and even occasional physical abuse that occurs, are all faced by a child in this situation. In addition, this child frequently is without the help or support of the nonalcoholic parent whose energies and attention are absorbed by the behavior of the drinking partner. The response of the child may range from overt acting-out behavior, such as running away, to passive withdrawal. The negative consequences of these attempts to cope manifest themselves not only in the immediate results but often continue into adult-

hood in the form of alcoholism or other disorders. Further, children labeled by society as runaways, delinquents, etc., are forced to carry these labels into young adulthood. These children are in serious need of nonstigmatizing services designed to intervene and support the development of positive coping skills. This need is overwhelmingly documented in the research literature.

Despite the obvious need for attention described above, there has been little action taken by those in the alcoholism field or by relevant agencies to deal with the needs of these children. In part this has been due to a lack of general awareness of the damage being done, lack of organized advocacy, concern for legal problems related to parental consent, logistical barriers related to gaining and sustaining stable caseloads, and a feeling of inadequacy on the part of the staffs of alcoholism programs treating parents. This feeling comes from the fact that the problems of the child are behavioral and often do not directly involve alcohol use although they may be alcohol related by virtue of the parental alcoholism.

As the dynamics of family alcoholism are increasingly explored, a very limited number of programs in the alcoholism field over the past 2 or 3 years have begun to service children whose alcoholic parents are in treatment, while a similarly limited number have tried to identify and service children who have alcoholic parents not yet in treatment and who may never accept treatment. These few programs are exploring a variety of techniques related to outreach, intervention, and prevention. They include such therapeutic approaches as group work, peer counseling and education, and individual and family therapy. Few have been completely successful, but several have overcome one or more of the barriers through perseverance or innovative techniques.

Little or no sharing of experiences has occurred that would be helpful to all, would allow a more rapid development in the state-of-the-art, or would provide a stimulus for more extensive program activity by both youth service providers and alcoholism service personnel across the country. In recognition of the need to define, record, and disseminate the emerging state-of-the-art in the provision of services to children of alcoholics and to stimulate the orderly and wider development of these services across the country, NIAAA sponsored the writing of this monograph. It is our sincere hope that it will receive the widest possible circulation not only among those in the alcoholism field, but also

among related social and health agencies, organizations, and individuals whose activities may bear upon the welfare of these children.

Willard O. Foster
Special Assistant to the Director
National Institute on Alcohol Abuse
and Alcoholism

Table of Contents

Foreword iii

Preface v

Symposium Participants xi

I. Purpose and Scope of the Symposium 1

II. Identification 7

III. Intervention 17

IV. Treatment 23

V. Prevention 30

VI. General Conclusions and Recommendations 39

Appendix A. Topic Papers by Discussion Leaders

Children of Alcoholic Parents: Issues in Identification
Lena DiCicco 44

Intervention With Children of Alcoholics
Kenneth H. Williams 60

Children of Alcoholics: Treatment Issues
Charles L. Whitfield 66

Prevention Issues Involving Children of Alcoholics
Patricia O'Gorman 81

Appendix B. Program Descriptions

County of Nassau, Department of Drug & Alcohol Addiction, Mineola, New York
Joseph C. Fern 102

The Children of Alcoholics: Program Needs and Implications Derived From Experience Within the Adolescent Alcohol Abuse Treatment Program—The Door, New York City, a Multiservice Center for Youth
Susan Landes ---------- 110

Omaha Area Council on Alcoholism, Omaha, Nebraska
Marc Lund ---------- 133

Working With Children of Alcoholic Parents in an Outpatient Alcoholism Treatment Facility and in the Schools
Ellen R. Morehouse ---------- 138

New Directions: The Family Center Youth Program, Human Relations Center, Inc., Santa Barbara, California
Wayne Muller ---------- 152

Rainbow Retreat, Inc., Phoenix, Arizona
Joanne Rhoads ---------- 164

Kolmac Clinic, Silver Spring, Maryland
Tarpley M. Richards ---------- 177

The Educational Aspects of Servicing the Children of Alcoholics
Janet G. Woititz ---------- 186

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I. Purpose and Scope of the Symposium

This chapter describes the purpose and scope of the symposium and explains the content of this monograph.

A. The symposium's purpose was to address both program and policy issues involved in providing services to children of alcoholics.

As articulated by NIAAA in its invitation letter to symposium participants, the objectives of the symposium were to:

- Define and record the emerging state-of-the-art in the provision of services to children of alcoholics by reviewing representative programs, analyzing critical policy areas, and assessing future needs.
- Stimulate the orderly expansion of those services across the country by disseminating a monograph and determining potential resources and types of interagency cooperation necessary, both within and among the alcoholism field (Government, voluntary, and private organizations) and other fields such as child abuse.

While the focus of the symposium was on children of alcoholics who are now chronologically children, it should be noted that there are millions of adults in our Nation who are also the children of alcoholics. These adults carry with them their experiences as children, and many have not resolved the meaning or the impact of those experiences on their adult lives. Reaching today's children is only a starting point; yesterday's children should not be forgotten.

In a practical sense, the symposium was structured to address the following questions in order to facilitate the development of policy:

- What is being done?
- What is known as a result of what is being done?
- What is not known?
- How do we increase our knowledge?
- How do we disseminate what we know?

- What actions should NIAAA take?

The goal statement for the symposium is provided in exhibit I.

B. The symposium focused on the areas of identification, intervention, treatment, and prevention.

The symposium took place September 24–26, 1979, and its agenda was designed to focus attention on four major issue areas:

- Identification
- Intervention
- Treatment
- Prevention

A copy of the agenda is provided in exhibit II.

1. *A representative sample of people involved in the field were invited to participate.*

Program, policy, and research professionals in the field of alcoholism were invited to attend. The list of symposium participants is provided on pp. xi–xiii.

2. *Discussion leaders prepared issue papers on the four major areas.*

Discussion leaders submitted papers and made introductory presentations to help focus the examination of each issue area. The suggested format for issue-area papers was:

- Identify and describe the major issues relating to the subject area.
- Review the existing literature in the field.
- Describe your perceptions of the major alternative approaches to providing services and the major assets and liabilities to each approach.
- Identify, describe, and assign priorities to those issues on which further research is needed.
- Identify and describe your perception of the barriers that must be overcome in order to provide needed services.

Issue papers are provided in appendix A to this monograph.

3. *All participants prepared program descriptions.*

The suggested format for program descriptions was:

- Brief history of program development
- Description of population served
- Description of staffing and services provided

- Description of areas in which you think the program has been extraordinarily successful in meeting service needs and explanation of why this is so; the lessons you can teach
- Description of areas in which you think the program can be improved and how you would do it; the lessons you still need to learn
- Specific issues you think should be discussed in each subject area: identification, intervention, treatment, and prevention

Program descriptions are provided in appendix B to this monograph.

C. The monograph's purpose is to document the discussion from the symposium.

In addition to an introductory chapter, this monograph contains chapters covering each area discussed at the symposium. They are identification, intervention, treatment, prevention, and general conclusions and recommendations.

The purpose of the monograph is to document what was discussed, not to make judgment about items presented. While many issues were agreed on by all participants, there was not agreement on all issues. The participation of any one person in this symposium should not be viewed as his or her endorsement of this monograph's contents.

The style of the chapters that follow attempts to communicate the substantive as well as the emotional content of the symposium's proceedings. To do this, in many cases, statements by symposium participants are quoted or paraphrased without attribution. Nonetheless, the ideas remain those of the symposium participants.

This chapter has described the purpose and scope of the symposium and has explained the content of the monograph. The next chapter covers the discussion about identifying the children of alcoholic parents.

Exhibit I
Goal Statement and Objectives: NIAAA Symposium on Services to Children of Alcoholics

GOAL STATEMENT

To produce a monograph on the emerging state-of-the-art in the provision of services to children of alcoholics.

OBJECTIVES

1. To convene a symposium of experts and field program people to:
   a. define, discuss, and record current program, policy, and research issues in the area of services to children of alcoholics
   b. review representative programs and discuss problem areas, strengths, and weaknesses of the current overall program direction
   c. assess future program needs
   d. review critical policy issues
   e. review types of interagency cooperation necessary, both within the alcoholism field (Government, voluntary, and private organizations) and between the alcoholism field and other fields such as child abuse
   f. prepare recommendations based on the foregoing areas to aid NIAAA in planning future program priorities
   g. identify information and human resources in the field
   h. provide a forum for subject-area participants to facilitate information exchange
2. To synthesize the information gathered at the symposium and prepare a monograph
3. To stimulate the orderly and wider development of services to children of alcoholics across the country
4. To promote interagency cooperation

Exhibit II

Agenda: NIAAA Symposium on Services to Children of Alcoholics

Monday, September 24, 1979

1:00–1:30	Opening Remarks	Henrietta Hubbard NIAAA John R. DeLuca Director, NIAAA
1:30–2:15	Purpose, Expectations, and Overview	Willard O. Foster NIAAA
2:15–2:45	Discussion/Questions	Stuart M. Matlins Moderator
2:45–3:00	Coffee Break	
3:00–3:20	Identification Issues—Presentation	Lena DiCicco CASPAR, Inc.
3:20–5:30	Identification Issues—Discussion	

Tuesday, September 25, 1979

9:00–9:20	Intervention Issues—Presentation	Kenneth H. Williams University of Pittsburgh School of Medicine Western Psychiatric Institute and Clinic
9:20–10:30	Intervention Issues—Discussion	
10:30–10:45	Coffee Break	
10:45–11:45	Intervention Issues—Discussion Continued	
11:45–1:00	Lunch	
1:00–1:20	Treatment Issues—Presentation	Charles L. Whitfield University of Maryland School of Medicine

1:20–2:45	Treatment Issues—Discussion	
2:45–3:00	Coffee Break	
3:00–5:00	Treatment Issues—Discussion Continued	

Wednesday, September 26, 1979

8:30–8:50	Prevention Issues—Presentation	Patricia O'Gorman National Council on Alcoholism
8:50–10:30	Prevention Issues—Discussion	
10:30–10:45	Coffee Break	
10:45–11:30	Prevention Issues—Discussion Continued	
11:30–12:30	Strategies and Recommended Next Steps	Stuart M. Matlins Moderator
12:30–1:00	Summary	
1:00	Adjournment	

II. Identification

This chapter summarizes symposium discussions related to identification of the children of alcoholic parents.

A. To help children of alcoholic parents it is first necessary to be able to identify them, but efforts to do this have been extremely limited.

A striking characteristic of most current approaches to the prevention and treatment of alcoholism is a seeming indifference to the needs of the children of alcoholic parents. For these children, their parents' drinking problem often is the central fact of their lives; their feelings, personalities, and behaviors are molded more by that one fact than by any other. Nevertheless, it is rare for these children's needs to be given attention by those adults and institutions with whom they interact. There have been few attempts to arrive at a systematic process of early identification and intervention with children from families with alcoholism.

B. Identification is the process that determines who the children are whose parents have alcoholism or other alcohol-related problems.

Although there is some concern that identifying the children of alcoholic parents can be a socially damaging "labeling" process, it is a necessary one if the special needs of these children are to be addressed.

1. *Four major purposes of identification were cited:*

- So that the nature and extent of service needs can be determined
- So that appropriate services can be made available and delivered
- So that these children may understand their potential risk level and options and make more informed choices about how they will deal with them

- So that the child's sense of isolation, guilt, and stigma can be reduced

When considering service needs, it is important to note that services can be indirect as well as direct and should include a broad range of service activities that include prevention and treatment.

2. *Identification activities may take place in many different settings, each of which presents special problems and opportunities.*

Identification activities may be carried out by focusing on the alcoholic parent, on children in general, or on children with special symptoms. Each focus suggests possible settings within which identification activities may be conducted. For example:

- By proceeding from the alcoholic parent to the children within the setting of an alcoholism treatment program or occupational alcoholism program
- By proceeding from children in general to the children of alcoholic parents within a school or recreational setting
- By proceeding from children with such special symptoms as physical abuse or criminal behavior to the children of alcoholic parents in a child abuse agency or in the criminal justice system

There is no one best setting for identification that is suitable in all circumstances and in all communities. An examination of each potential setting in terms of the opportunities for acceptance and success and of the problems that must be overcome should be done individually within each community. This is the only way the most appropriate environment for identification activities can be determined. The one consistent factor among all communities, however, is that cooperation with other agencies and institutions will be required.

Listed below are some possible settings for identification. It is not intended to be all-inclusive:

- Schools
- Treatment centers and providers
  - —child guidance
  - —outpatient programs
  - —family physician
  - —school nurses
  - —alcoholism treatment facilities (residential, outpatient day hospital)
  - —child abuse agencies

—case workers
—mental health practitioners (private and public)
- Criminal justice system
- Recreational centers
—Y's
—churches
—boys' and girls' clubs
- Group foster homes/shelter care
- Occupational programs

3. *Other than alcoholism treatment centers, schools and recreational programs appear to be the most promising settings for identification activities.*

Given limited resources, two major criteria might be considered when determining possible settings for identification activities:

- The potential to reach the largest number of children and, as a subset, the largest number of children whose parents have alcoholism or other alcohol-related problems
- The degree of difficulty in gaining acceptance and in implementing identification activities

After considering a broad range of settings based on the experience of participants in the symposium, schools and recreational programs generally were thought to be the most promising ones. They both offered a high potential to reach the largest number of children, and both were accessible within a tolerable degree of difficulty. Other comparatively promising settings for identification activities were alcoholism treatment facilities and human service agencies dealing with children (child protective, child casework).

C. There are a variety of barriers to carrying out identification activities.

In many communities there is often resistance to conducting identification activities in general and within specific settings in particular. An understanding of the nature of this resistance may be useful in anticipating and even overcoming it.

1. *Ignorance of why something should be done and ignorance about what do do.*

- Professional schools provide limited instruction about alcoholism and even less about its effect on family members. As a result, health professionals, educators, and social service

personnel often are not aware of the problems, do not know that something should be done, and fail to help their young patients, students, and clients to cope with one of the most potent and formative confusions in their lives. In addition, many social agencies do not even recognize the existence of parental alcoholism in the families with which they are working or the needs of children affected by it.

- In some cases, a lack of training leads to inaction because teachers and others do not know how to identify and explore fully the extent of the problem or need.
- In other cases, service providers know that something should be done but do nothing to identify the child because they do not know what to do with the information once they have it. A referral mechanism is unknown or unavailable to them.

2. *Emotional and professional attitudes.*

- An inadequate level of interest in the children of alcoholics also may be a reflection of the attitudes of caregivers, agencies, and the community in general toward alcoholism.
- There may be a willingness to deny the existence of alcoholism and, therefore, to deny the special needs of children of alcoholics.
- There may be a tendency to overlook symptomless children because they are not acting out in destructive ways and, as a result, are more difficult to identify.

3. *Priorities of caregivers and of alcoholism treatment programs.*

- Often the focus is only on the alcoholic person.
- The program frequently cannot treat the children and the parent so a choice is made: The child is ignored in favor of the more obvious and/or pressing needs of the parent.
- Children often have primary problems of their own that are compounded by the attitudes of an alcoholism counselor.

4. *Avoidance.*

- Ambivalence and confusion exist about who should provide help to the child.
- An attitude or belief is expressed that identification of the children of alcoholic families is a job for specially trained clinicians only. It is "not my job" as a teacher, social worker, clergyperson, etc.

- A clear-cut administrative mandate is lacking within the school, social service agency, or other institutional system that giving attention to the children of alcoholic families is a legitimate concern.
- Teachers and others may not receive administrative and program support when they do identify the existence of a problem and try to effect an intervention.

5. *Fear.*

- Adults may fear the pain created by calling attention to the existence of a problem.
- Fear may exist of potential legal action for "interfering" with someone's child.
- Fear may exist of doing more harm than good by taking inappropriate action.

6. *Legal barriers.*

- The actual or perceived legal status of the child inhibits or precludes identification that may result in services or treatment without parental consent.

7. *Attitudes and feelings of the children.*

- The children may distrust teachers and others who might be able to obtain or provide help after identification. They may also fear that their confidentiality will not be respected.
- The children may fear physical violence from the parent(s), sibling(s), or friend(s).
- There may be constraints of the parental relationship when: parents intimidate their children and order them to keep silent about the parent's alcoholism; the children feel loyalty toward the alcoholic parent because of concern that the parent may be embarrassed or punished; and the children feel shame about the existence of alcoholism in the family.
- The children may have a fear of bigotry; they may think they will be treated differently once people know about their parent's alcoholism. Such a fear inhibits self-identification.

D. To overcome the barriers to identification activities, efforts should focus on health-care providers, institutions, children, and parents.

Overcoming the barriers to identification may be a long and difficult task, but the existence of programs in different parts of

the country shows that it can be done. Experience suggests that efforts should focus on both the institutions in the community and the individuals within and outside those institutions who control access to children and, hence, the children's access to needed services, including:

- Teachers and other school personnel
- Human service providers
- Primary care physicians
- Law enforcement personnel
- Alcoholism treatment staff
- Clergy
- Recreational leaders
- National Council on Alcoholism affiliate staff
- Child and protective services personnel

At the same time, the potential role of the children, their parents, and peers should not be ignored.

1. *Pre-service and in-service training of the health-care providers is a major requirement for the successful implementation of identification activities.*

A great need exists for specially trained people in all professions who deal with children. Training could take place as part of pre-service or in-service professional education of the health-care provider and should develop awareness as well as provide skills. The major purposes of training are to:

- Provide a rationale for why identification activities should be carried out. The rationale should be problem-specific, addressing the particular needs and opportunities of any given situation.
- Convince trainees that it is their responsibility to participate in identification activities.
- Identify the trainee's own biases and feelings abount drinking and alcoholism.
- Be factually informed about alcohol and alcoholism (what it is, how you define it) and values related to drinking.
- Provide the skills necessary for self-confrontation.
- Be skilled in confronting people with drinking problems, in working with families, and in speaking in a way that is both sensitive and free of prejudice.
- Be skilled in confronting children from families with alcoholism.
- Be knowledgeable about referral.

2. *Some Do's and Don'ts for the training of professionals are based on the experience of symposium participants.*

- Do recognize that you can't change attitudes until you provide the skills with which to change them.
- Do use a trainer with whom the group can identify. Too often trainers alienate the group by their appearance or by their manner of speaking.
- Do present the need for training and action in terms of benefits that are meaningful to your immediate audience, not benefits meaningful to you or some other audience. Know what your audience is interested in and will accept.
- Do include experienced trainers who have worked in the field and can get children involved in discussing their personal problems. Too often trainers are people who come in, train, and then leave.
- Do encourage trainees to increase their personal exposure with alcoholism by attending open AA, Al-Anon, and Alateen meetings for information and for emotional insights, particularly about their feelings as outsiders.
- Do provide incentives for the trainees to continue. These may be minimal monetary, special credit, or recognition incentives. Be imaginative in choosing them.
- Do have training provided by people who have undergone the same kind of training that they will try to provide. The people doing the training have to go through the same kind of soul searching.
- Don't create a defensive or hostile atmosphere.
- Don't demean others for their lack of knowledge.
- Don't select a trainer based on political expediency. Instead, base your selection on the trainer's professional qualifications.
- Don't proceed until everyone has examined his or her own biases and feelings; otherwise end results are likely to be counterproductive.
- Don't proceed until you obtain a specific time commitment and administrative support.
- Don't hold the training sessions in a huge auditorium where it is difficult to hold people's attention and attendance. The training environment is very important.
- Don't antagonize people with an arrogance that suggests you are trying to teach them something they don't know, or that somehow they need you. Suggest the opposite: You need them.
- Don't allow anyone to conduct training sessions who has a prejudicial attitude or is not able to be supportive.

- Don't use a professional for the training who is not from the professional group you are training, i.e., use social workers to train social workers, physicians to train physicians.
- Don't go in unprepared. Know the support system and the resources in the community, as well as the politics of alcoholism in that community, before you start training.
- Don't base your training mainly on acquiring facts and figures. Base it on achieving a more caring and personal attitude as well as on the ability to communicate.
- Don't minimize your effectiveness with excessive ego involvement. If your success or failure as a person depends on the reception, then you will accomplish very little.
- Don't assume that you have not had an impact or made an impression if you don't get immediate feedback. In fact, be suspicious when you do get immediate feedback.
- Don't forget to make the training meaningful to the group with which you are speaking. Make your own information connect with their own personal and professional experiences.

3. *Other actions directed at institutions may be taken to build awareness and overcome the barriers to identification.*

Actions directed at overcoming institutional barriers to identification should seek positive change while building awareness of a problem that society should address. Some practical suggestions for action at the community level are provided below and are based on the experiences of symposium participants.

- Create community support to get the school system to provide an administrative mandate to encourage and allow teachers and school administrators to identify these children.
- Elect concerned individuals to Health Systems Agency and health, criminal justice, and other advisory and planning boards. Persuade and educate staff members about the issue of identification.
- Work to educate the personnel of Government departments in order to influence their program priorities, particularly in the areas of alcoholism, mental health, and social services.
- Make persons responsible for employee alcoholism programs aware of the needs of the children of alcoholics.
- Persuade health maintenance organizations to develop screening techniques and then to screen clients.
- Work to establish local, dedicated taxes on the sale of alcoholic beverages for use in education and treatment. These taxes also will build a general awareness of the needs of these children.

4. *Identification includes self-identification as well as peer and parent identification*

It is not always necessary or even desirable to look to health-care providers or institutions for identification. The children themselves may come forward to get help if the right things are done. Peers and parents also may be assisted to effectively and constructively carry out identification activities. All the following suggestions can help children of alcoholic parents self-identify.

- Create a "space" where the child can self-identify. The fact that there is often a lack of overt symptomatology, is, in itself, a barrier to identification. We frequently rely on the children to identify themselves and come forward. Perhaps in education courses an opportunity can be provided where children can come to somebody they trust and say, "We've got this problem."
- Reach children in the environments in which they are most comfortable.
- Provide help in a way that protects privacy.
- Provide a factual framework on how alcoholism affects them and their family.
- Be aware that peers also may be used to reach out, identify, and help. The opportunity may exist for training and/or simply informing peers about how to approach their friends who need help.
- Remember that parents may identify their children, particularly as part of their own treatment.

E. Symposium participants make recommendations for NIAAA concerning intervention activities.

Symposium participants recommended several actions that NIAAA could take to assist with identification activities. Some require only a decision to do them; others involve important policy implications.

- Develop and/or collect training outlines and course materials and make them available to facilitate training of professionals and others. Outlines should provide information on the range of training activities that currently are being conducted so that interested persons may start from a base of existing knowledge and select the approach that seems most appropriate for them.
- Make information available in places where children congregate in order to encourage self-identification.

- Provide information about programs that are successful, especially programs that include valid kinds of evaluation. In selling a program it is helpful to demonstrate that it has been used successfully elsewhere.
- Prepare and disseminate information on the legal status of children in relation to identification activities and on ways to cope with the system.
- Use NIAA's influence with other health-care professionals and sister agencies to help them incorporate NIAAA's training and testing materials and information on alcoholism. For example, NIAAA could encourage local schools of social work to include this material in their curricula. If, on the master of social work test that a Department of Education gives, there are questions on alcoholism, then the social workers will have to be informed about it, and the schools will have to teach more about it.
- Pursue the feasibility of requiring that NIAAA-supported grant projects indicate how they will better serve families affected by alcoholism (including children of alcoholics) either directly or indirectly by referral or cooperation with other agencies.

This chapter covered symposium discussions on identification. The next chapter deals with intervention.

III. Intervention

This chapter summarizes symposium discussions related to intervention with the children of alcoholic parents.

A. Intervention with this population is the act of direct or indirect contact with children, parents, or significant others for a specific purpose.

Once identification has taken place, intervention must follow or the process of identification will have been pointless and even may be harmful.

1. *Intervention includes stepping in and reaching out.*

Contact with the child may be direct or indirect, but, to be successful, it must be empathetic, a kind of "communion."

- Stepping In:
  —Direct contact and communication with the child
  —Indirect actions to increase the child's awareness of the problem as it relates to him or her
- Reaching Out:
  —On behalf of the child, either directly or indirectly

2. *The major purposes of intervention are identical to those of identification, but there are also some additional purposes.*

As an extension of identification, intervention shares the purposes set out in chapter II, section B.(1). In addition, intervention should:

- Create the proper environment so that the child will accept appropriate services.
- Alter children's perception of themselves so that they can understand their predicament, and the feelings and behaviors that result from it, so that they can turn their situation to their own benefit.
- Give children a sense that they have control over their environment and can make responsible choices.
- Facilitate the recovery of the alcoholic parent and the family.

3. *Intervention may be approached in many ways.*

Other approaches to intervention that should be considered are:

- Work through the sober spouse of the alcoholic. Often there may be indecision or confusion about "forcing" the children into treatment, and, as a result, encouragement is needed. Many symposium participants said that their experience showed this to be one of the most productive approaches to intervention.
- Make intervention part of an alcoholism treatment program where children may be involved directly in the treatment of the parent, or treatment of the parent may be used to intervene separately with the children. Sometimes it even may be desirable to make intervention with the children a required part of treatment programs in order to provide relief to the parents by removing the burden of the decision from them.
- Use the resources of self-help or peer groups, such as Alateen.
- Set up a teen drop-in center or similar place where children congregate as an information branch. The information may encourage the child to self-identify and seek any needed services.
- Educate pregnant women in clinical settings regarding fetal alcoholism syndrome.
- Encourage self-intervention by providing information and by sharing experiences and feelings.
- Regard parents as partners who help deal with other behavioral problems that the children are manifesting.
- Work through specially trained and sensitized caregivers who interact with children in the identification settings discussed in the previous chapter, health and mental health institutions, emergency rooms, councils on alcoholism, hot lines, and community health information and referral agencies.
- Use the resources of the information and entertainment media.

B. In addition to the barriers to identification that inhibit intervention, there are other special problems in this area.

The barriers to identification discussed in chapter II, section C, affect nearly all phases of intervention as well. But symposium participants also identified additional barriers to intervention and focused on some special facets of previously discussed ones. These are listed below:

- Legal issues may become a factor inhibiting direct intervention with the child.

- Parental resistance can prevent access to the child.
- The child's own coping mechanism may involve denial of the existence of alcoholism and of the need for any help.
- Ethical issues may become involved. For example, do people have the right to intervene with someone else's child?
- Lack of knowledge may exist because the education of physicians and other health-care providers does not adequately address alcoholism, let alone children. There also may be a lack of knowledge by "agents" on how to intervene and how to talk to children.
- Appropriate persons may not be used for intervention. Sometimes recovering alcoholics have difficulty with intervention because of personal biases as a result of their own experiences.
- Professional staff may have difficulties in dealing with some issues like inappropriate sexual behavior.
- There may be conflicts in the therapist's interest, that is, a therapist may be assigned to a parent and child at the same time.
- Intervention may not take place at the appropriate time.
- Intervention may not occur at the appropriate place. The image of the institution within which intervention takes place may have negative effects, e.g., a hospital setting means you are "sick."

C. Advice about carrying out intervention activities and getting others to intervene is based on participants' own experiences.

Symposium participants drew on their own experiences in making suggestions to guide intervention activities and in helping to approach third parties about intervening with the children of alcoholic parents.

1. *It is important to be well prepared before intervening with the children of alcoholic parents.*

Based on their experiences, symposium participants offer the following advice to someone who is about to intervene directly with a child.

- In approaching the child, be sure well in advance that you know exactly what you are doing and are prepared to deal with most eventualities. The most difficult situations often arise when many facets of a single problem are revealed for the first time, frequently all at once.
- Be direct, honest, and sensitive.
- Pick an appropriate time and place to intervene, someplace

with a climate of safety that is free from harmful kinds of labeling or stigmas. Don't pick a place where an objective observer could say: "I know why you are seeing so and so."

- Don't be ego-involved. People think they have to fortify their courage to such a point that they withdraw at the child's first negative response. You have to remember you are doing this primarily for the child, not yourself.
- Appeal to the child's strengths and to what he or she is able to do under adverse conditions. Focus clearly on the skills developed by the child.
- Choose the gentlest forms of intervention.
- Don't minimize the problem. Treat children as individuals by meeting them on their own level.
- Let the child know that there is a place in the treatment center for him or her. At the same time there is also a place for the parent.
- Demonstrate understanding. Let them know you are aware of what goes on in the alcoholic family.
- Don't expect an immediate, affirmative response. Say: "This is something that you might want to do or that might be useful to you later even if you can't use it now, but I just want you to know."
- Don't minimize or discount any incident. All are important.
- Be sensitive to the things that are special about a particular child in contrast to other children who have problems. Some of those things might be feelings of guilt and shame; symptomless children experiencing different levels of isolation that result from the neglect of caregivers; parents who act unpredictably; different feelings of helplessness, of being trapped; feelings that everyone knows there is a problem, but no one does anything about it; variations on the belief that the parent has willed the problem: "If he loved me, he wouldn't do it"; "If I were lovable, he wouldn't do it."
- Remember: Your goal is to get the children to a place where they can get help. You don't need to be doing the treatment.
- Assure children they can come back to you, that you are not abandoning them if things don't work out.

2. *Special skills are needed for approaching third-party caregivers to get them to intervene.*

Symposium participants offered the thoughts listed as a guide to approaching third parties to get them to intervene with a child of an alcoholic parent:

- Hire qualified staff to do the intervention. It's not something that everybody can do. Special skills and special talents are required.
- Be aggressive when discussing the need for intervention.
- Convince the third-party caregiver that the need for working and intervening with the children of alcoholic parents is a crucial one.
- Be persistent. If you try to get the caregiver to intervene and it doesn't work the first time, don't abandon your efforts.
- Keep your expectations low and be aware that simply raising the issue is therapeutic. Get a sense of satisfaction even if nothing happens. And keep trying. It's important.

D. Participants make recommendations for NIAAA on intervention.

Recommendations for NIAAA action related to intervention are listed below:

- Pursue the feasibility of conducting further research on how to intervene with these children.
- Provide a small stipend for adolescents coming to a series of after-school groups, including attending Alateen meetings. The money allows teens to camouflage that they are coming for help. They often explain to others that they have a "job" at the Center. It also enables them to engage in intervention without parental knowledge—an essential when both parents don't want anyone to know the family "secret."
- Encourage research on the vulnerability of these children in order to understand the children and their needs so that better intervention strategies can be developed.
  - —The specificity and severity of needs will vary with each individual child according to his or her circumstances and the presence of actual resources to meet his or her needs.
  - —The needs of children of alcoholic parents differ from those of children of other dysfunctional parents in quality, if not in kind.
  - —Research findings would imply that, for whatever reason, children of alcoholic parents are the highest risk population for alcoholism identified to date and, therefore, should be a prime target for prevention.
- Conduct research on what, if anything, is medically and physically special about these children.
- Encourage people who currently are working with these chil-

dren to publish their findings so that they can be made available to others.

- Seek agenda time at national and State conferences to focus attention on the needs of children through discussion groups and the presentation of papers.
- Encourage medical schools to require that pediatricians and physicians during their residencies pursue information on the needs of children of alcoholic parents and how to intervene with them.
- Urgently suggest that all States that receive formula grants provide services to children of alcoholic parents at all alcoholism treatment centers and provide training in intervention to social and health-care providers.

This chapter covered symposium discussions on intervention. The next chapter deals with treatment issues.

IV. Treatment

This chapter summarizes symposium discussions related to treatment of the children of alcoholic parents.

A. Treatment is the process of providing the services needed by the child. It is not necessarily a formal therapy program, but it may include activities usually thought of as "prevention."

Many people think of treatment only as a formal program of therapy. But in relation to the needs of children of alcoholic parents, that is a mistaken concept and one that is harmful because of its limited scope.

1. *The functions of treatment in this context relate both to present need and preventing future problems.*

Treatment for these children serves two equally important functions:

- Dealing with specific presenting problems
- Preventing future problems for high-risk children who currently do not have those specific presenting problems

2. *Given the children's needs, the nature and content of treatment must be thought of in new ways.*

For the children of alcoholic parents, treatment might provide one or more of the following:

- A supportive environment in which positive change can occur
- Education that is age appropriate for self-understanding and for understanding the disease of alcoholism
- Motivation to change and give up destructive behavior

In addition, treatment in this context should not be thought of only as a formal program of therapy; if it is, many of the children's needs will continue to be unmet. Treatment might involve a variety of things, including:

- Offering the children a stable relationship
- Letting the children experience their own powers as people

- Providing caring and loving, as well as corrective emotional experiences, that establish a link with positive mental health
- Allowing a child to borrow an ego for a while
- Providing, in the person of the therapist, a coparent or substitute parent for a period of time
- Helping the children develop ways of dealing with decisions that are unique to their environment, e.g., what to do if they bring someone home and a parent is drinking
- Setting appropriate behavioral value limits, as opposed to inappropriate ones or none at all, because often these children have no clearly defined parameters for conducting their personal lives
- Teaching and helping the children survive
- Providing an "island of safety"
- Educating the children about the nature of alcoholism, its dynamics and the recovery from it; self-understanding; ways of coping; resolution of guilt, anger, and frustration; and how to relate to other children

3. *Assessment of treatment needs may be particularly difficult because of problems unique to the situation.*

The problem assessment and definition stage of the treatment process has some unique aspects for the children of alcoholic parents. Treatment providers should be aware of and sensitive to these aspects. There may be no presenting problem, no visible symptoms, no accurate developmental history, or no history at all.

4. *Treatment must be provided in a way that is accessible, convenient, and confidential.*

Because children have limited mobility, the logistics of providing treatment are extremely important. The service provider has greater mobility than the child and should think in terms of where he or she can go to make treatment accessible to and convenient for that child. In addition, the child's right to confidentiality in obtaining treatment must be respected.

The following places where treatment might be made available were suggested by symposium participants.

- A special place for the purpose such as an after-school place that doesn't have a sign on it, or a comfortable place that doesn't jeopardize the confidentiality of the relationship
- Schools where service providers can come at certain times each week
- Church

- Alcoholism treatment facility, if accessible, and/or if the parent is being seen there
- Community mental health center
- Recreational facility

B. To provide treatment, attitudinal and institutional issues must be addressed.

Treatment for the children of alcoholic parents is not easy to provide. There are barriers to such treatment, some of which relate to issues discussed in previous chapters. There are also special issues that must be addressed in the process of providing any treatment. Symposium participants identified the following issues in order to help others carry out treatment activities.

- Denial and ignorance keep children from receiving treatment.
- Parent(s) is/are usually not in treatment and may object to children receiving treatment.
- Legal barriers exist to providing treatment to children without parental permission or over parental objections. Children often are treated as possessions, not as individuals.
- Funds must be obtained to pay for treatment. Diagnoses that can be reimbursed by third-party payors must be found and used for initial treatment. In addition, providing funding for continuing treatment can be difficult.
- Administrative and institutional barriers in treatment programs restrict services to children. Children often do not count in a census for treatment facilities when calculating reimbursement by funding sources.
- Intake procedures frequently are insensitive to children because the process is formalized and divided among several people; children, particularly younger ones, need to establish a continuing one-to-one relationship from the start.
- Staff with appropriate skills may not exist in programs presently offered in the community.
- Stability of the treatment setting may be difficult to maintain because staff turnover can be high. This is particularly difficult for children to deal with, and it has a negative effect on the trust that must be developed with them.
- Caregivers are co-alcoholics and may have their own damaging biases.
- Trust is difficult to establish between the alcoholic parent and child.
- Coordination of treatment between the parent and child is de-

sirable but frequently is difficult or impossible because of attitudes of the parent, child, and/or caregiver.
- Appropriate treatment modalities in a community may be limited.
- Innovation and resources for treatment may be lacking.

C. Symposium participants give advice for providing treatment.

As in previous sections, outlined below are symposium participant suggestions to guide treatment activities.
- Hire specially trained and skilled staff and screen for a solid commitment on the part of those staff.
- Be consistent and honest from the first contact to the last, no matter where you decide to have treatment available or who you hire.
- Make the child a primary client with respect to treatment, regardless of the alcoholic's and co-alcoholic's behavior; but try very hard to include one parent in treatment.
- Involve the family in treatment to the greatest degree possible.
- Have a staff that can deal comfortably with pain.
- Have a staff with a genuine concern for children.
- Recognize the child's need to become autonomous.
- Provide responsive treatment, that is, treatment available when the child is in crisis and not long after.
- Have a staff that can be consistently firm and caring at the same time. Firm means to respond honestly, to give honest answers to the child and to the family, and to set limits. Help the family to structure and focus on what their goals are and to evaluate the process that leads to those goals. Do this directly and avoid passive or other nondirect responses.
- Provide treatment as an "add on" to other services the child currently receives by conducting special training for the other service providers.
- Think of treatment as an ongoing process that may take months or years. Treatment goals may be as ill-defined as allowing the child to choose and to adapt to the ongoing changes in life. Treatment is not an event that begins and ends within a short time.
- Develop a treatment model that all program staff can use or be trained to use in order to achieve consistency.
- Be strict about defining staff roles because most of these children's needs are so great that staff can be overwhelmed in taking care of them. Adequate supervision and backup are essential.

- Ensure that treatment is accessible to children as well as suitable for them in terms of language, approach, and style.
- Fit the type of treatment to the age of the child. In general, the younger the child, the more individualized treatment has to be; as the child grows older, more group treatment should be used.
- Group children during treatment in most cases.
- Teach the children about the forces that shape their lives and how to alter or control those forces.
- Teach them how to be children; many of these children do not know how because they missed out on a lot of normal childhood experiences. Teaching them how to be children is important, especially when the alcoholic parent recovers, comes back in the home, resumes the roles to serve his or her own needs, and sends the child out to play and the child doesn't know what to do.

D. Symposium participants give recommendations and ideas for NIAAA and others.

As a result of the discussion of treatments, symposium participants identified areas for possible action by NIAAA and others and also suggested ideas to stimulate thought about some important treatment issues.

1. *Research needs are many concerning the treatment of the children of alcoholics.*

Symposium participants emphasized that there is so much that is not known about the treatment of the children of alcoholic parents that presentation of a list of research needs could be dangerously misleading. It might be misinterpreted because the reader might think that all things not listed are therefore known. That is simply not the case. With this caveat in mind, listed below are some questions about research areas that symposium participants thought to be of particular interest.

- What age is best for treatment? Is there an ideal age?
- What specific treatment approaches work, how do they work, and how well? Evaluation is needed to identify successes and failures, and findings should be published.
- What are the implications of treating siblings in group counseling and therapy sessions when parents are not present? Is it better to put siblings in two different groups or to pair them?
- What is the relationship between a child's growth and the co-alcoholic's responsibility for that same growth? If the child is being seen without one of the parents being in treatment, he

or she will jeopardize family stability. Unless the co-alcoholic is also in treatment, the child's treatment will be undermined by the co-alcoholic. Co-alcoholics have to be involved somewhere along the line to make them an ally of the therapist.

- What is the best timing for joint family therapy? When is it appropriate to bring the child into joint treatment? Should it be with the sober parent or with the alcoholic?

2. *Participants made recommendations for NIAAA on how to improve treatment.*

Participants identified specific actions that might be taken by NIAAA and other concerned institutions and individuals to improve the treatment provided to the children of alcoholics.

- Disseminate information from as many places as possible to interest the most groups. This should be done primarily by people in the field.
- Devote more time to writing and publishing the things people active in the field have learned for the benefit of those who have absolutely no idea what is being done. At this stage it probably would be better to publish in existing journals rather than to create a new journal dedicated to this field.
- Increase the number of alcoholism schools that offer instruction on counseling children of alcoholics.
- Encourage the development of more programs for the children of alcoholics and the incorporation of special children's services into existing programs.
- Develop innovative marketing techniques to gain acceptance for new concepts about needs and approaches to treatment and to persuade traditionalists within the caregiving professions to implement them.

3. *Treatment "fantasies" suggest possibilities for the future.*

Participants were encouraged to articulate what they would like to see happen regarding treatment. These ideas are set out below to stimulate thought but not necessarily as recommendations for action. The treatment of the children of alcoholics is a new field. We are all still in the early stages of learning; there is a need to be imaginative.

- Initiate national treatment information.
- Provide highly accessible treatment, such as in a storefront drop-in center for teenagers in a shopping mall, a place where children are going to play the pinball machines, for example. Have a drop-in center with directive counseling on job training

for dropouts that would instruct them on how to fill out a social security card. Many children from the homes we are talking about have had no parental guidance at all. They have no idea about how to go about getting a Graduate Equivalency Diploma, and they have practically none of the usual skills that children are taught as they are growing up.

- Establish an in-elementary school service for pre-adolescents.
- Consider the possibility of mandating in all NIAAA programs by 1982 that the grantee come in with an add-on piece for treating children of alcoholics and for outreach techniques for identifying more—a very modest staffing grant to add to a supplemental grant. In addition, NIAAA could provide the needed technical assistance.
- Provide an Outward Bound type of program that gets children out and in groups for a variety of learning experiences.
- Work in creative ways to reestablish the harmony of the family system. Treatment programs tend to isolate family members from each other rather than bring them together.
- Have all caregivers, from teacher to pediatrician, be sensitive to the needs of children and committed to getting them to needed services either in or out of their facility.
- Prevent funding channels from becoming so specialized that they can't accommodate the needs of more than one kind of person.
- Have small community mental health centers for children of alcoholic parents established in neighborhoods and communities throughout the United States. These centers would be highly accessible to the children.
- Get the family into treatment the day the alcoholic person enters treatment.

This chapter covered symposium discussions on treatment. The next chapter deals with prevention as a separate area, but it should be remembered that, in the context of children of alcoholic parents, treatment includes prevention.

V. Prevention

This chapter summarizes symposium discussions related to prevention as it applies to the children of alcoholic parents.

A. Primary prevention of use-related alcohol problems combines policies and strategies, including interventions, designed to redirect or reduce the impact of etiologic and intervening variables.

As discussed in the previous chapter, treatment for children of alcoholics is not just therapy; it includes activities traditionally thought of as prevention. As it relates to these children, prevention is not just education. You can also isolate drinking problems that you think are going to arise because of the way you treat them. In a sense, prevention is the flip side of treatment in that it views the individual's potential for problem development and attempts to prescribe interventions which would reduce the likelihood of those problems. Due to its targeting on specific areas for intervention, prevention has an orientation similar to treatment, but since it addresses a range of probable problems, it has a broader scope than treatment. Thus, prevention has an orientation that is somewhat more expanded than treatment.

As a treatment strategy, prevention should be regarded as having many of the following dimensions:

- In prevention you're looking at a developmental sequence of issues. Depending on who and where you are, you're going to be intervening at some point. What you intervene with will be some sort of policy direction, program, or other form of impact on the environment to make something happen. This intervention goes beyond educating somebody because the one thing we know about education is that it must be supplemented or augmented by followup help in the form of a policy initiative in the school or in a special program, or it may be all of those things.
- When thinking about prevention many people think of education. But education is only one strategy. If you look at prevention as a behavioral outcome and also examine social psychol-

ogy research, such examination will tell you that you can change many attitudes without changing behavior. Prevention is more comprehensive, although it is a controversial area. Some people say you have to change belief systems, and, since AA is the best way we have, we have AA as a model. But this model offers no clear-cut alternatives when looking at behavioral outcomes. If you say a given population has a higher degree of risk for a certain behavior, and want to make sure this behavior does not develop, then you have to look at a variety of other strategies and not just education.

1. *The children of alcoholics are a high-risk population in both the short and long term.*

The children of alcoholic parents are a unique high-risk group for the development of long- and short-term problems in terms of health, mental health, and alcohol-related problems. They are longitudinally and situationally at risk. This risk concept is the starting point for prevention efforts and is discussed in detail in the paper "Prevention Issues Involving Children of Alcoholics," by Patricia O'Gorman, Ph.D., provided in appendix A of this monograph. Some key points from the paper are highlighted below.

2. *There are basically three approaches to the prevention of alcohol-use-related problems.*

The three basic approaches to prevention of alcohol-use-related problems involve:

- Changes in the social and environmental conditions threatening health
- The availability or accessibility of alcohol itself
- Individual behavior

On a programmatic level, primary prevention involves a behavioral or consequential outcome that may be based on information and education. This distinguishes it from information programs that have a purely knowledge-retention outcome and education programs that use facts to affect values but do not necessarily go beyond this to alter behavior.

3. *Prevention approaches must be tailored to the needs and circumstances of the child.*

As Dr. O'Gorman points out, the challenge for prevention approaches that deal with children of alcoholics is how to tailor them so that they do not stigmatize the child, yet can help the child develop appropriate coping mechanisms.

Children of alcoholics must be helped to cope with what they already know: that their families are in some way different and that they may develop an alcohol-related problem. In this context there are many issues that should be addressed. For example, it is necessary to know who and what you want to reach and to tailor approaches to reach that group. It is necessary to be very specific about what you are going to address in the child of the alcoholic, whether it is prevention of alcoholism and/or other health and mental health problems.

B. Additional barriers inhibit prevention activities.

The barriers to carrying out other activities related to the children of alcoholics that were discussed earlier in this monograph also inhibit prevention activities. Several, however, merit special note in relation to prevention:

- The symptomless person is a barrier in any primary prevention. You are looking at a symptomless person, and you are trying to prevent something the person doesn't have.
- A feeling of *inertia* fosters the belief that alcoholism cannot be prevented as well as other misconceptions that inhibit dealing with a sensitive, uncomfortable issue.
- The absence of carefully designed and controlled research results in a *lack of knowledge* about what to do and what works.

C. Prevention is a complex subject, but activities in this area can create positive results.

Prevention was the most difficult subject discussed at the symposium, reflecting its complexity when dealing with children of alcoholics. But this difficulty does not stem from an absence of positive results gained from prevention activities. Rather, it reflects the multifaceted nature of the subject and the barriers to its realization that were discussed above. To help others interested in prevention activities, participants were asked to share what they felt were the benefits to be gained from prevention based on their clinical experience. Responses are summarized below.

- When children are educated about alcohol and alcoholism and how it is affecting their behavior socially, emotionally, and in school, children feel less burdened by the parents' drinking, understand their parents better, and understand their own reactions better.
- Life improves for these children when their definitive structures have been modified through early treatment, early inter-

vention, and from being offered early assistance. How do you offer early assistance? For example, by gathering all the children in a certain age group and working with them for more than a month and monitoring the art work they produce. The children who have more primitive, definitive structures than others can be identified. Those that don't have overt problems get further counseling and go on. Those that still are burdened with denial, rejection, and splitting, are treated in long-term care for about a year between the ages of 6 and 12. Their egos will mature, and it is to be hoped they will experience additional fundamental changes.

- The children begin to relax a little and love a little. They become less fearful and begin to see themselves as subjects, not objects.
- "They come out of their shells. They come out of their withdrawal. They start talking. They are a lot more open. They get free of this cloud that is hanging over their heads all the time."
- Out of prevention comes case finding and early identification of children at risk: those who come from homes that have a drinking problem or who might need treatment now or later.
- Children can develop real survival skills that are not self-destructive. They can recognize the part, as small as it may be, that they are playing in what is going on in the family. They can become aware of the risk of developing alcohol and nonalcohol problems in life. This may be done primarily by group work with adolescents, developing their ability to relate and demonstrating accepted survival skills.
- In the classroom, at the sixth-grade level, the programs have acted as case-finding mechanisms. Many times the children of alcoholics will come up and identify themselves. Then we see them, usually in the guidance office, and refer them to a treatment agency.

D. Symposium participants present advice for conducting prevention activities.

As in previous sections, symposium participants shared their experiences about prevention activities and made suggestions to guide others in conducting their own prevention plans. Among those suggestions are the following:

- Recognize that much of the problem has nothing to do directly with alcohol. A lot of it has to do with learning to take re-

sponsibility for one's behavior, learning how to make decisions, and learning how to make difficult choices.

- Recognize the value of pure information and be able to differentiate between information and education.
- Understand that early treatment is a form of prevention; it's getting children before they develop any overt symptoms and trying to find out what you can't see. In a sense, prevention is getting someone in treatment before the problem gets worse.
- Enlist the support of community leaders and provide an opportunity to talk to them. Sell them on the idea of prevention. If you invite other people in the community to get to know you and learn where you are headed, there will be fewer problems.
- Prevention is essentially a basic problem in community action. There, the alcohol issue is a sensitive one, but it can be approached from the prevention perspective if talked about honestly with whatever knowledge you have.
- Look at the alcohol-related problems within the community that the community itself wants to resolve. Solutions at the prevention level are in the community's interest. Focus attention on problems the community can recognize and wants to deal with, such as school dropouts, vandalism, and involvement in the criminal justice system.
- Use dealing with these types of problems as an entry point to getting people together and then suggesting your own agenda. Be subtle in your approach. To call what you want to do "alcoholism programs" would be disastrous.
- Mobilize your forces and go to your frontline people, your social service agencies. They will become the backbone of caring activities in the community.
- To start a prevention program, you might have to do without funds temporarily, which means you might have to rely on volunteers. But you have to develop a constituency. Frontline social service people should do this, but they usually don't. You have to start getting people to work who are in need of this service, like the children themselves. Gather a group of children in a way that protects their confidentiality. Get a "pied piper" and bring people along behind. You may have to start without money because, if you wait for money, it may never come. You must have people willing to sacrifice by devoting their time.
- Put together a "power" group, but pay particular attention to the people who are in unique positions to obstruct it before

it becomes operational. Talk with the AA representatives in town. Tell them: "We are going to do an education program in the schools, and we wondered if you'd be interested in serving on a group. One of the first things we are going to do is have an evening seminar on what we are going to do and how we are going to do it. Would you come to dinner to discuss your role? We know we can rely on you."

- Don't do what we did in the area of drug abuse and march into the high school to lecture the students on the evils of drug abuse; don't tell them, "Here's how you can recover if you get addicted."
- Mount a public campaign directed at women who are of childbearing age to inform them about the risks of drinking during pregnancy. The campaign also should be directed at physicians and other health-care professionals in the area to inform them about the effects of alcohol on the unborn child.
- Children of alcoholics often have a distorted perception of reality. They don't know what the truth is. They may lie frequently but they are not necessarily conscious of lying. If we want to prevent problems, we have to get them in touch with reality or provide a way they can do it themselves. In terms of prevention, this would entail something very basic where the word alcohol may never arise. Until they have a sense of what reality is, we can't even begin to talk about responsible drinking and nonresponsible drinking. They don't have positive models. Until they learn what the real world is, they think that all home life is like their world.
- Children of alcoholics can't get a sense of reality in a homogeneous group. Therefore, primary prevention has to start where there's a mix of children. The best place for that mix is in school. As a result of this mix, the children will know there are homes where alcohol is used differently; that some people, including children in the first grade, drink wine at the table with meals, and that this is not a sinful or dangerous habit.
- If you don't have employee-assistance programs in your community, start them, because prevention strategies for children will be ineffective if adults haven't been treated.
- Do not portray any member of the alcoholic family as a victim. They are not victims. These children and spouses are accomplished survivors using techniques many of us will never learn. See them as people who have skillfully and courageously endured.

- "In our coping groups what we do is we start out where the children are. We give them treatment and education and try to help them understand the situation that they are living in, help them learn some skills, make some changes, make them realize how alcohol is affecting them. We go into a prevention kind of activity and say: 'OK, you're part of a high-risk group; this is something you have to face. If you're going to drink, have you made that decision? Are you aware of the risk factor that's involved?' "
- There is one paradox we have to recognize. We say that you have to have a symptomless person or symptomless child for primary prevention to occur. But we also are dealing with symptom-ridden children to varying degrees. Whether in large numbers or small, we are dealing with both types of children—asymptomatic and symptomatic—and that's a paradox we have to accept or come to terms with.

D. Symposium participants give recommendations and additional thoughts for NIAAA.

As a product of discussing prevention, symposium participants identified areas for possible action and followup by NIAAA. Some of the items listed below suggest specific actions; others identify general areas of need or suggest a general direction for policy and/or programs. It is important to emphasize that many of the suggestions are for action by concerned people working on their own at the community level without Federal financial assistance.

1. *Public awareness can be increased through a variety of activities.*

- Public education should be used to focus people's attention on the problem; encourage community discussions regarding these issues; and, we hope, lead to community action.
- Raise the awareness of adults through advertising, as the poster campaign about child abuse has done.
- Raise the awareness of children, particularly small children, by working through television programs such as "Mr. Rogers" and "Sesame Street."
- Use the media to inform the public about what happens to a child in a home with alcoholic parents.
- Consider using NIAAA's influence to get this topic discussed

in plenary situations in all professional meetings, associations, or conferences.

2. *Changes in the grant process and procedures should reflect new ideas and trends.*

- Encourage submission of grant applications from frontline people to do research rather than from people in an academic or laboratory environment.
- Revise the grant review process and insure that reviewers are sensitive to new ideas and trends in the field.
- Consider emphasizing the needs of this population in program guidelines.
- Clarify where these children's services belong and at what level and stimulate innovative and comprehensive approaches to their service needs.

3. *Programs and research on the prevention of use-related alcohol problems should be expanded.*

- Consider dissemination of program information as a high-priority item, a "prevention package," containing components that can be used to meet the specific needs of each particular community.
- Stimulate other agencies to educate health-care professionals about this issue.
- Make alcohol education a high-priority target so that public schools can have sufficient resources, trained staffers, curriculums, etc., for health education that will include alcohol education.
- Encourage the establishment of school-based programs that will include education for the general public in school and community groups, specialized educational services for the children of alcoholic parents on how to deal with alcoholism in their families, and identification of the children who have alcoholic parents and who already are abusing alcohol.
- Encourage education for school and community groups, health professionals, and related people in the area of alcohol use and its implications.
- Provide an opportunity for dialog which could lead to more accurate strategies in early identification.
- Encourage a treatment for living in an alcoholic home and all the things that go along with that and promote specific kinds of prevention activities. Start with education that would inform children about their risk factors and what kind of things (if anything) they could do to lower that risk.

This chapter covered symposium discussions on prevention. The next chapter deals with why society should address the needs of children of alcoholics and provides recommendations that relate to the entire subject of the symposium rather than to any one topic covered.

VI. General Conclusions and Recommendations

This chapter addresses the issue of why our society should devote its limited resources to the needs of children of alcoholics. It also provides general recommendations about the subject of the symposium.

A. Why should we do anything about the children of alcoholic parents?

Symposium participants' specific answers to the question are provided below.

- "Because the most serious consequence is damage to interpersonal relationships, and if you are treating these people at an early age and helping them overcome that very serious handicap, it is worthwhile. All you've got is people, and if you don't have that, then I don't think you've got anything else."
- "Because it's such a waste if we don't. We are wasting our own children. And it is irreversible. It's something that we can put our energies into, a known problem. We know it is a problem, but we don't know how to deal with it. We can tell you how we do it, but we don't know why this is an area we can go into. Why waste these children?"
- "Because in all levels of our population, old and young, it's a commonly treatable problem."
- "Because it represents a huge economic drain, and it cuts across all socioeconomic groups. It's not a class problem."
- "The population in need is huge. The situation they find themselves in, the pain and suffering, is needless suffering based on even the very Neanderthal knowledge that we have at this present time. It's still needless. When those children are in that situation, there is nothing without outside help that they can do to help themselves. They are a deserving group."
- "Because we do have tools which would have great impact in

terms of preventing mental health problems, alcoholism, learning, and other problems."

- "Because they are overrepresented in all the other areas of concern, be it juvenile justice, mental health, school problems, and physical health problems, and it's the one label, if you will, that is able to transcend all those different problem areas."
- "Because people who are in alcoholic families, who grow up in alcoholic families, and people who move through the pain and growth of that process come out as some of the most creative, intelligent, beautiful people. By providing services, it helps to prevent later problems. The people who are ending up in our institutions would instead end up as real visionary community leaders."
- "They are worth it."
- "It is the responsibility of a society to treat its epidemics."
- "Because children of alcoholic parents suffer a very real degree of deprivation and, on the other side of it, have a very real strength that needs to be encouraged and developed."
- "Because they are ignored, overlooked, badly in need of attention, and because people aren't aware of the need. Information is not disseminated among those who should know."
- "The children of alcoholics should represent a challenge to NIAAA from a public health service point of view. It is possible to look at this disease and alcholism problems as a public health issue, and it should be possible as a public health agency to make a difference and actually improve the health status, in one way or another, of individuals that are involved. The children of alcoholics lend themselves to this approach, not only because of their great need, but also because the issue would lend itself to this kind of public health approach."
- "Because it probably is a fully cost-effective method to prevent increases in the problems or to decrease problems of the incidence of alcoholism."

B. Participants give general recommendations about the subject of the symposium.

In addition to recommendations relating to specific topics discussed in earlier chapters, participants made some recommendations that dealt with the general subject of the symposium.

- There is a need for a national constituency of advocates for the children of alcoholic parents and a need to secure the necessary attention, public and private funding, and services.
- NIAAA could prepare and disseminate information on the

legal rights of children to obtain treatment without parental consent or in spite of parental objections.

- Programs are needed at the local level that should obtain active, readily available, responsive legal counsel to assist in clarifying and dealing with the legal barriers in this field in general as well as on a case-by-case basis.
- NIAAA should attempt to clarify and resolve the conflicts in State alcoholism, drug abuse, child abuse, and protective regulations so that the children of alcoholics may obtain the services they deem appropriate without parental permission.
- Public and private organizations should work to clarify the ethical issues, such as the following, involved in the field:
  —Intervention and treatment without parental permission
  —Treating someone based on whatever body of knowledge we have at the present time
  —The issue of whether parental alcoholism constitutes emotional neglect and abuse of the child
  —Determining when it is appropriate to turn a case over to protective services
  —Determining what is the child's right to treatment
  —Determining how the child's confidentiality can be protected
  —Determining your responsibilities to the parents if you are seeing the child
- NIAAA should obtain Joint Commission on Accreditation of Hospitals inclusion of an accreditation requirement for services to children of alcoholic parents.
- NIAAA could explore provision of grants to States for the training of special children's counselors who can provide direct services and also be advocates to other agencies and institutions.
- NIAAA should consider sponsoring more small group symposia for people already working in the field to exchange ideas and information and to help overcome professional isolation.

This concludes the monograph summary of the symposium. The appendixes that follow contain papers prepared on each topic area by discussion leaders and program descriptions prepared by all participants.

APPENDIX A

Topic Papers

Children of Alcoholic Parents: Issues in Identification[1]

Lena DiCicco, MPH

The Phenomenon of Avoidance

It is striking to note that it has been almost 5 years since the National Institute on Alcohol Abuse and Alcoholism published its landmark report, *An Assessment of the Needs of and Resources for Children of Alcoholic Parents* (1974).

The indifference accorded this report during the half decade since its release illustrates in unmistakable terms the single most powerful barrier to identifying and providing services to this highly vulnerable group: the phenomenon of avoidance. The report outlines with great perception the sociological and structural barriers that have created the vast chasm between the needs of children of alcoholic parents and the resources available to them. These same barriers must account for the fate that befell the report itself. It is my hope that this week's meeting will lead to the implementation of many of this report's still valid recommendations.

Among the major strategies the report identifies as necessary in overcoming barriers to helping children of alcoholic parents are:

- Public education
- Professional education
- Policies and guidelines for program operations
- Fiscal incentives
- Research and demonstration grants

The last-named strategy—research and demonstration grants—

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[1] Sections of this paper are based on publications of Charles Deutsch of the CASPAR Alcohol Education Program Staff, supported by an NIAAA Grant.

I believe explains the presence of our Somerville program here today. It is gratifying to be here.

For a wide range of reasons, the "conspiracy of silence" that has plagued the illness of alcoholism over the centuries operates in spades in its impact on the individual family members who are as deeply affected as the victims of the illness themselves but are less likely to receive treatment.

In order to help children of alcoholic parents, it is first necessary to identify them, but a most shocking characteristic of current treatment approaches to alcoholism is a seeming indefference to this population. There are perhaps 20 million youngsters whose parents' drinking is the central fact of their lives, children whose feelings, personalities, and behavior are molded more by that one reality than by any other. No one with whom these children have contact is paying even the slightest attention to that fact.

Incredibly, professional schools still teach almost nothing about alcoholism and even less about its effect on other family members. In consequence, educators and social service personnel of all types fail to help their students and young clients to cope with the most potent and formative confusion in their lives.

There are other obstacles besides ignorance. Alcoholism is an emotional subject. Major barriers arise from the internal characteristics and attitudes toward alcoholism of caregivers, agencies, and the community in general.

Groups Vital to the Process of Identification

In looking at the process that identifies this group in need of services, I find useful an NIAAA diagram, which delineates the potential support systems for children of alcoholic parents. It includes the child, nuclear and extended families, general community contacts (including school personnel, physicians, and clergy), child and family programs, alcoholism treatment programs, and specialized resources for children of alcoholic parents (NIAAA 1974, p. 74).

Over the past 8 years (5 of which were funded by the NIAAA Division of Prevention) we at the Somerville program have had the immense good fortune either to create or to have access to each of the support systems listed above.

Somerville, Mass., is a blue-collar city of 85,000 adjoining Cambridge and Boston. The CASPAR Alcohol Education Program is one component of a comprehensive alcoholism program which, in turn, is part of the large, sprawling Cambridge and

Somerville Mental Health and Retardation Center associated with Harvard Medical School. Last year, the Walk-in Emergency Service and Outpatient Department staff of our alcoholism program served 6,500 patients and family members.

Our treatment personnel and, more currently, the staff of our women's program traditionally and systematically attempt to engage spouses and children of all our patients in small treatment groups. The effort expended to reach family members is enormous when compared to the small number who actually enter into treatment, for reasons that I am sure are well known to this group.

A very small number of affected children do find their way to treatment for alcoholism in the family. Alateen and alcoholism services reach only a small number for several reasons:

- Because of the stigma of alcoholism, some children want to deny both that a parent has a drinking problem and that it is affecting them so much that they need to seek help for themselves.
- Seeking help is considered juvenile or unsophisticated.
- Sober parents often deny that their children are affected.
- Parents with acute alcoholism forbid their children to seek help.
- Resources are not widely known.

The importance and benefit of treatment for the whole family is cited in the literature. Specifically, intensive treatment of the nonalcoholic spouse as well as the children, even if and when the alcoholic member abstains, is recommended. Clearly, however, children have needs of their own that must be treated and met regardless of the parents' ability to seek help.

The experience of our alcoholism treatment program has convinced me that we must develop ways to help children from families with alcoholism early in their lives before the illness takes its most tragic toll, and that this help cannot be contingent upon first identifying and treating the alcoholic. The number of American children with parental alcoholism can be conservatively estimated at 20 million. It is clear that these youngsters, and the adults they become, make up a large percentage of our school dropouts, juvenile and adult offenders, our chronically unemployed and mentally ill, our drug abusers, and our alcoholics. Yet there have been few attempts to arrive at a systematic process of early identification and intervention with children from families with alcoholism.

The Public School as a Structure for Identification and Support

In an NIAAA-National Center for Alcohol Education analysis of potential service provider groups to identify and help young poeple at risk, it was concluded that the school setting met the most crucial criteria. This study recommended that such services be offered in schools that have ongoing objective, fact-based, teacher-trained alcohol-education programs.

In today's discussion I will be drawing liberally from the experience I know best: our demonstration/research Somerville project. It is a school-based support system with the potential for impacting on large numbers of children of alcoholic parents in need of identification and help. I must also confess that our work with children of alcoholic parents is a serendipitous outcome of a carefully planned, primary prevention project in which we never anticipated the large numbers of children that appeared in Somerville.

Over a period of 2½ years the CASPAR Alcohol Education Program has had contact with 140 children of alcoholic parents who have received help through out-of-school, time-limited groups. The vast majority of these children, generally 12 to 18 years of age, came from homes where neither parent was in treatment and where, most particularly, the sober parent was denying the problem and was not able to give the children any understanding of what was happening in the home.

If I could make only one point in this presentation, it would be that CASPAR's work with children of alcoholics can now be seen as a natural and even inevitable outgrowth of its school-based, primary prevention program. We are convinced that there is no shortcut that will prove comparably effective; a school-based primary prevention network is the key to systematic work with children of alcoholics before their troubles become obvious and more difficult to reverse. And trained teachers, rather than guidance counselors or school nurses, are the heart of that prevention network.

Our Somerville education program has two full-time and one half-time education staff members, two administrative staff members, and a full-time evaluator. It helps youngsters make responsible decisions about drinking or abstaining, drawing heavily on the findings of the studies of alcoholism rates among different American ethnic groups. The program has five components: teacher training, curriculum development, peer educa-

tion, community training and consciousness-raising, and evaluation of all activities. About 2 years ago, two new secondary prevention functions were integrated into the primary prevention program: a component dealing with youthful problem drinkers and one for children from families with alcoholism.

A. *The Goals of Alcoholism Education*

Somerville teachers are trained to teach alcohol education. According to plan, most youngsters from grades 7 to 12 will receive a 10-session unit in virtually every school year. Our concentration on the elementary grades is a more recent development. Alcohol education in Somerville includes learning about alcoholism but, contrary to the practice in many school systems, the two processes are not identical. In a typical CASPAR teaching unit, the first seven sessions are devoted to understanding drinking situations; the final three sessions are about alcoholism. This order ensures that the alcoholism segment does not have the effect of a "don't drink" message, which some still feel is the goal of alcohol/alcoholism education but which CASPAR believes to be both hypocritical and counterproductive.

Many children with alcoholism in their families don't recognize moderate drinking and literally can't recognize it even when they see it. The CASPAR model of alcohol education tries to present images of the responsible use of alcohol. The first seven sessions help children to establish a cognitive schema or societal norm against which they can compare the drinking of their parents. Without such a norm it is sometimes impossible for them to realize that there is anything wrong with the way their parents drink.

So alcoholism must be included within an alcohol-education unit, but the goal in teaching about alcoholism is *not* to discourage young people from drinking. The overall goals of the alcoholism unit are twofold: to help students understand and cope with the consequences of familial alcoholism; and to train them to recognize a problem-drinking pattern, or alcoholism, in themselves or in others, and to know where to get help. The latter is a useful learning goal for all children but its effects upon their lives are obviously remote. On the other hand, helping youngsters deal with family alcoholism they live with every day can radically improve their present and future lives and future chances.

Although adolescence is almost, by definition, a continuous series of crises and trauma, it is well known that teenagers don't generally avail themselves of mental health services. They don't

come for help voluntarily, and they can't be forced into prolonged therapy. For children of alcoholics beset by guilt, shame, and isolation, the consequences of this avoidance are greatly multiplied. Furthermore, no one they know, and especially no adult, ever talks about alcoholism. Not only can youngsters not identify anyone to whom they can talk, there is no one to whom they can just listen. Alateen is, of course, excellent for those who reach it, and we do all we can to involve the youngsters we reach. But as one psychiatrist told us recently, as difficult as the task may be, he can attract alcoholics to AA and spouses to Al-Anon much more easily than he can draw a child to Alateen without strong parental support.

Consequently, the goals of an early intervention program for children with family alcoholism should be realistic. To be sure, the result of intervention with some children is membership in Alateen or some other kind of long-term therapeutic relationship, and some children even have become factors in their parents' recovery. But the most attainable goal is much more modest and just as worthwhile, especially if it is brought about early in the child's life; that is, simply to help the child understand the central fact of his or her life—the alcoholism of a parent and its effect on the family. That understanding has both cognitive and emotional elements. Children who are too guarded and guilty to express or examine their feelings can still take in, and wrestle with, ideas about family alcoholism. These ideas, presented coherently by someone respected and trusted, can eventually equip the children to understand their feelings and to express them.

B. *Working With Children From Alcoholic Families*

We can speak of five stages in our work with children from alcoholic families: pre-identification, identification, referral and intake intervention, and followup and reinforcement.

Pre-identification—Teaching About Alcoholism. We regard the teaching of our curriculum "Decisions About Drinking" (CASPAR 1978) as the pre-identification stage. Over 150 Somerville teachers in grades 1 to 12 have undergone 20 to 40 hours of CASPAR training, which includes attending an AA and Al-Anon meeting and listening to an Alateen speaker. Training is a prerequisite to any Somerville teacher's undertakings in the unit.

A teacher can initiate help in a way that no guidance counselor can because a teacher talks with 30 children and singles out none. A teacher initiates alcohol education as a subject; a counselor responds to it as a problem. And, of course, many of

the youngsters most in need of an opening are those who are not yet in visible trouble: the superachievers and the withdrawn. Because the teacher raises the subject of family alcoholism in full view of everyone, not cloistered in a cubbyhole, an atmosphere gradually is created in which it is "OK" to talk about alcoholism and not joke about it.

It should be emphasized that, even if no one child reacts to the subunit on family alcoholism in a manner that identifies the child to the teacher, or if one does identify himself or herself but cannot be coaxed into seeking further help, the teacher can still be assured that the subunit has helped significantly. Just as with alcoholics, help is more than the instant in which the child of an alcoholic expresses a problem; help is an incremential process that is not always shaped like a dialog.

We stress five teaching objectives for the segment on family alcoholism. We wish to communicate to the children of alcoholic parents that

- They are not alone. The shame and isolation accompanying the illness allow youngsters to remain ignorant of their many peers who are in the same boat.
- Their parent's alcoholism is not their fault (guilt is always present).
- Alcoholism is a disease. Most youngsters are eager to be convinced that their parent is not a hateful person but a sick one.
- Alcoholics can and do recover. Many youngsters find help for themselves only after they go out looking for a way to help the alcoholic.
- They need and should get help for themselves. It should be clear that the youngster can feel better independently of what goes on in the family.

The same teacher who identifies and refers children with family alcoholism provides invisible but immeasurable help to many youngsters not yet ready to reval themselves simply by teaching a well-planned unit that includes family alcoholism.

Teachers' Fears:

1. "What can I do, I'm only a teacher?" Yes, but the teacher is probably the only person in the child's life calling alcoholism by its name and suggesting it be talked about openly. Now that we are adults, we tend to forget that when we were children there were some adults, often teachers, with whom we could actually talk. Most people think of help in capital letters, glowing, skilled, professional, with more personal attention than a teacher in a room full of students can

give. But help is first of all listening, simply validating a youngster's emotions; and for these children, that is a lot of help. If the stage is reached at which a referral can be made, that is more than help, that is miracle working.

2. "But what if some kid flips out, breaks down on me? What am I going to do with the other 29 students? Never mind that, what am I going to do with the one kid?" There are things a teacher can learn to do, but that is not really the issue being discussed here. The underlying concern is "Why do I want to make a child feel pain?" as if seeing it were causing it, or as if making it apparent were making it worse. Youngsters do not burst into tears very often, but when they do, the teacher must recognize that they are already receiving a great deal of help.
3. "You know how kids are. I'll start talking about alcoholism and one kid will say to another, 'That sounds like your father.'" First of all, it rarely happens, even when it is intended as a joke. Secondly, anything done by or to a student during an alcoholism segment can be the pretext for a talk after class and, in that sense, represents an opening. The teacher's goal in such a talk simply is to express concern and a willingness to listen.
4. "And the first thing you know, I'll have some parent screaming at me, and my principal will be nowhere in sight." Confronting parents is every teacher's nightmare, and, while the teacher is wise to be prepared for it, it rarely materializes because parents hiding alcoholism are not likely to come into school and confront a teacher on the subject. Consistently positive feedback on the alcohol-education units and the absence of negative parental reaction have helped solidify the support of the Somerville school administration. Without such administration support, teachers in other communities would be justified in refusing to teach alcohol and alcoholism.
5. "Now that this poor kid is all upset, what am I going to tell him? Where can he get more help?" Even after teachers recognize the considerable extent of their own help, they are rightly concerned that the responsibility for further help be passed on to more appropriate agencies. For many young people Alateen is ideal; some need more structured, individual attention, or adult contact. Guidance counselors or mental health professionals can be helpful unless they have no training or understanding of alcoholism, which is altogether too common and has adversely affected many youngsters. A com-

munity that asks teachers to teach about family alcoholism is obliged to provide them with resources dealing with it.

Identification. As soon as teachers begin teaching about alcohol they discover children with problems at home. Fortunately, this discovery happens while they are still in training with CASPAR staff because their first teaching experience is required as part of the 20-hour Basic Alcohol Education Workshop. Thus, they learn how to deal with children from alcoholic homes when the problem becomes real to them.

To prepare teachers to identify children of alcoholics, CASPAR trains them to look for certain "critical features" that are either hints or sure signs that the child's family has a problem drinker. Teachers have substantiated that seemingly innocent request and after-class hesitation (often just "hanging around" after class while others ask questions or a prolonged searching in a desk for papers even in the earlier sessions about drinking and alcohol) are tentative ventures at asking for help. Teachers must also recognize terminology. Youngsters from alcoholic homes literally cannot conceive of moderate drinking and equate it with drunkenness. So, when many children say, "My mother drinks," they mean "She gets drunk."

I've focused on teachers as identifiers because they have been our most important and generally underrated source. But CASPAR reaches children with family alcoholism in other ways. Trained peer leaders conduct structured alcohol-education workshops during study hall and after school, open to anyone, and we typically find that one-third of the participants are identified as having alcoholic parents. These group participants, in turn, refer their friends, with a predictable expansion of influence.

Aggressive Intervention Works. Referral and intake procedures are simple and can be succinctly summarized. In most cases, teachers and agency personnel refer by phone, while many children refer themselves. They may participate in a single-session alcohol workshop as a condition for going on a camping trip with the "Y" or as a requirement for a jobs program and end up leaving their name and number and expressing a desire to be in a group. Sometimes an individual interview is needed, usually done by a peer leader who is also the child of an alcoholic.

Although referral and intake procedures are simple, there are two main reasons why referral works (and that about two-thirds of the children we identify reach the program):

- There is little or no stigma to participation. The teachers have

done a great deal to bring alcohol and alcoholism into the open. Our peer leaders are proud to work for CASPAR, and everyone knows who they are. Most of the after-school workshops that peer leaders conduct at our office are open to everyone, so it is not assumed that only children of alcoholics or children with drinking problems come to CASPAR.

- The reason that we attract a diversified group is that after-school workshop participants are paid $2 an hour, or about $40 at the end of the workshop. For some youngsters, the money is the reason for coming; for others it is a lure that loses meaning once the workshop starts; for many it provides an excuse to make to parents and friends: "It's a job, I just go there for the money." It amounts to what? Since money isn't difficult to raise locally, $4,000 is such a small amount to help 100 children for 20 hours each. How many adults do you know who would sit through a 2-hour workshop after 6 hours of school without some tangible reward?

Most of our intervention with children of alcoholic families takes place in structured groups composed entirely of children of alcoholics, with as narrow a range in age as possible, and conducted by a pair of carefully trained and supervised peer leaders who are themselves children with family alcoholism. Until recently, we had limited these groups to the 12- to 18-year-olds who could come to our center after school.

Elementary In-School Intervention. After establishing CASPAR we had the rare opportunity to pilot a program for early elementary grade youngsters who have been designated as children with special needs and who are mandated to receive specialized services by State law. Parental permission was obtained through letters of consent allowing children to attend alcohol discussion groups. One can only guess at the proportion of youngsters in this group who have learning disabilities, hyperactivity, and acting-out behavior stemming from alcoholism in the home.

A member of our staff and a special needs teacher who had undergone 40 hours of our training led two pilot groups that met weekly for several months and quickly named themselves the "Top Secret" group. (This name emerged out of the first meeting's discussion of the need for confidentiality.) Since not all youngsters could be accommodated, we established a waiting list. Interest has quickened among teachers in other schools. It was no accident that this pilot program was launched in an elementary school with an active PTA, a progressive principal, a core of alcohol-trained teachers, and in a neighborhood of Somerville

in which a leading resident is the chairperson of our program's steering committee as well as the spouse of the ward alderman.

We are fortunate in being an integral part of an extensive treatment network provided by both our alcoholism and our mental health programs. We make referrals and share many of our children with a variety of caregivers, health-care facilities, and overnight shelters.

Training as a Prerequisite for Successful Results. In addition to the stigma of the illness, another equally potent force must be reckoned with in working with children of alcoholic parents: Children have no rights and, in the eyes of the law, are a socially valuable commodity, a "protected property." It is with great reticence and caution that outside agencies, especially schools, tread on the sacred ground of parental "ownership."

To overcome the natural fears of school and agency personnel that any dealings with parental alcoholism can be dangerous, we have designed training programs to affect the heart as well as the head. Selected films and Alateen speakers make vivid and real the everyday pain of children living in homes with active alcoholism. Only with such frank and persuasive techniques will adults forget their fears and become aggressive enough to take the initiative in talking and listening to youngsters and in trying to intervene constructively.

In this process it is important to build credibility and arouse the consciousness of school administrators, community decision makers, and caregivers so that they will at least let your program happen. They don't have to become active proponents—merely silent supporters. Of course this challenge entails building community support and taking some risks. Gaining parental permission may seem important but it also can be used as an excuse to do nothing and thus deprive adolescents who are sick and living in a sick home situation from getting much-needed help. Adolescents are mobile and capable of taking positive steps for their own survival when pointed in the proper direction by an understanding adult "outsider."

This is the role that our teachers and agency caregivers have assumed. We provide the training according to a model we have painstakingly developed and evaluated over the years.

But aggressive identification and referral must be counterbalanced by an extraordinary sensitivity to the issue of confidentiality. In 5 years we have run into no problems on this issue. School personnel who are willing to help children from homes with alcoholism are characteristicaly attuned to the nature of the

illness they are dealing with and to the life-threatening circumstances their students are in.

One more word about training. It is not enough to say that training is a primary requisite for something to happen at the community, school, or agency level. It is the kind of training that is vital. We now know how many hours it takes, what kind of reinforcement is needed, and, most important, the methodology that is essential to produce attitude and behavior changes in our primary agents. (So little attention is paid to the design of appropriate objectives and dynamic methodologies.) It seems as though most alcohol/alcoholism training is designed to fail. In the face of pervasive cynicism about education, I am pleased to state that alcohol education can succeed. Evaluation of our Somerville program tells us so

Earlier we described NIAAA's (1974, p. 74–a) diagram of *Potential Support Systems for Children of Alcoholic Parents.* If I have concentrated on just one of these, the school, and slighted others, it was intentional. The alcohol-related problems of 20 million children are so pervasive "that one must apply a public health approach to solutions." One must ask "What is the most cost-effective program that will have the greatest impact?" First, I assume that we agree with the statements that every child of an alcoholic needs to be identified in order to receive some kind of help and that the nature and extent of the help can vary from an educational program (of varying length) to intensive psychotherapy.

A small minority of these youngsters has already engaged the attention of the law through acting out and other antisocial behavior. Others will get some emotional support from professional helpers in guidance clinics and family and children's agencies because of learning or behavioral problems or because of withdrawn behavior. But the truth is that the vast majority of children from homes with alcoholism look so much like their age peers—with a wide range of intellectual abilities and social and coping skills—that they will continue to slip by. Their special needs will go unattended unless they are dealt with in a carefully planned, nonthreatening, natural way by adults who see them every day and are trained to intervene.

We cannot wait for our alcoholism treatment centers to engage parents in the recovery process and hope that caregivers will have the resources and the skills to engage the children in treatment. This would reach too few, too late. Our alcoholism treatment program never has more than a small number of children in

treatment at any given time, and few youngsters continue for more than a year.

In 3 years' time and as part of a pilot program growing out of our school-based primary prevention effort, our education program has reached 93 youngsters, most of junior high school age, in 20-hour, peer-led psychoeducational support groups to address their needs as children of alcoholic parents. We also estimate that one-third of the youngsters who have come to our center's after-school Basic Alcohol Education Workshops are children of alcoholic parents.

Breaking the Generational Cycle of Alcoholism

Aside from the collection and quoting of statistics, which we professionals do very well, little has been done about the overwhelming evidence surrounding us that alcoholic parents (one or both) frequently produce alcoholic children. Nancy Cotton's painstaking review of all studies in the last 40 years conservatively estimates that almost one-third of any sample of alcoholics studied will have at least one parent who is alcoholic (1979). Some studies cite a 50 percent figure.

In our program, we have conducted groups for court-mandated young problem drinkers at the Easton Middlesex District Court in Cambridge. As the groups progressed and the young people felt free to talk, 60 percent revealed they had alcoholic parents, and an additional 20 percent were known to come from alcoholic homes.

Why has this group, children of alcoholic parents, which has a higher risk of contracting alcoholism than any other we know, been so ignored? I suspect that part of the answer has to do with fearful decision makers who are themselves children of alcoholic families and cannot acknowledge the threat they have lived with for so many years. Forming policy for and allocating resources to a problem one has never overcome is a task that is tragically self-defeating.

Also, society tends to let parents define their children's needs. We know that the stigma of alcoholism, the guilt, confusion, and paralysis of will it creates, makes most parents unable to recognize and ask for help for their children.

There is a discrete but highly essential task that only the schools can handle in dealing with this highly vulnerable group. Most children of alcoholics eventually will drink in spite of their protestations and will do so with a volatile combination of fear,

guilt, and fascination unless they gain a new perspective on drinking, or on strategies that make abstinence more possible.

We have been struck by the incredibly negative attitudes toward alcohol shared by children (even first graders) who grow up in alcoholic homes. But their attitudes are no mystery, given the lack of positive role models for drinking and the sometimes daily physical assaults that accompany a parent's drinking. It is important for these children to learn about alcohol in a setting like the classroom where they have a chance to hear other youngsters' more neutral and sometimes even positive views on drinking.

In grades in which peer group drinking begins, the mixed classroom group becomes even more important. Children who drink for release of tension, or to achieve personality change, or to emulate a parent, can perceive their own motivations as dangerous when they listen to classmates and engage in a dynamic alcohol-education curriculum.

Recommendations

I have spent considerable time describing the schools as a primary agent and resource for identification and programing. Obviously, school personnel should be trained and assisted in this special task. Of course, physicians, clergy, human service agencies, and law enforcement and alcoholism treatment agencies also have an important role to play in identification of this high-risk group. But they also must be trained, since so few graduate schools offer any help in dealing with the illness of alcoholism. The ultimate Children in Need of Service (CHINS) are the children in alcoholic homes.

All Federal agencies whose job it is to help maintain the health and well-being of our children and young people could benefit from an overall directive defining children of alcoholic parents as a group in need of specialized services for which school systems can be reimbursed. We are proud to report that we have accomplished this in Somerville. We are currently under contract to provide services to youngsters from homes with alcoholism under Chapter 766, the Massachusetts law mandating services for young people with special needs.

Public and professional education would help, as would conferences and seminars. Changes in the legal rights of children would also be helpful. But the definition of this long-neglected group as one legally in need of special services for which agencies

could be reimbursed would go further than any other single action I can think of in achieving the goals for which we all are reaching.

To make progress in this long-neglected area, NIAAA must exert its leadership and reorder its own prioities and allocation of resources. Only then will NIAAA be able to engage its peer agencies in the Federal bureaucracy toward the intensive, cooperative effort needed to deal with this vulnerable group. Can anyone think of a single more powerful stroke of prevention, capable of stemming the overwhelming problems of mental illness, drug abuse, and alcoholism that beset this country?

Federally funded efforts should be supported long enough and with sufficient built-in skillful evaluation to measure the impact individual programs make on this problem. Two- and three-year demonstration grants are not the answer. No area merits funding longevity more than this one.

To summarize, we have demonstrated on a pilot basis in Somerville that it is possible to identify and help a large number of children of alcoholic parents. We accomplished this by creating a community support system that enabled us to train teachers in a public school setting so they could provide appropriate educational services and refer youngsters to the proper allied educational services.

Much to our surprise, we have shown that it can be done. We are convinced that we have created turning points in the lives of many of our children.

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Intervention With Children of Alcoholics

Kenneth H. Williams, M.D.

I have been asked to deliver a formal presentation about my knowledge in the area of alcohol intervention and related issues as they affect children of alcoholics. I found preparation of this paper rather difficult, but I am nonetheless willing and able to talk about my experiences.

The letter of invitation to this symposium stated that I had been selected to participate as a primary speaker because of my "extensive experience in this field." In fairness, I cannot describe my experience with children of alcoholics as "extensive," but I can say that it is a special interest of mine, at least in part, because I am the child of an alcoholic parent. Six years ago I attempted to work with the teenage children of my alcoholic patients. I learned you can't be therapist for both at the same time. I also was largely responsible for the establishment of a special group-therapy program for children of alcoholics. Through this experience, and in attempting to refer children to Alateen, I learned that it is very difficult to refer children of alcoholics to a source of help. Since these two failures, I have followed the suggestion of Willard O. Foster, Jr., NIAAA, and have simply and privately shared my own experience with other children of alcoholics, most of whom have been medical students or others in the helping professions. This sharing has been helpful to me and, I've been told, helpful to those with whom I've shared. Through these hours of sharing I have gained some insight into the difficulties children of alcoholics are likely to encounter.

It seems to me that the major issue relating to the subject of intervention with children of alcoholics is that it is a very difficult thing to do. Most alcoholics in this country never make it to treatment because of the denial system and, in part, because of the stigma of alcoholism. The family, an integral part of society, accepts the stigma and often denies and covers up the

disease, which makes it very difficult to intervene with the alcoholic. The children, as part of the family system, participate in the denial. Another factor is the lack of information concerning what alcoholism is. As a result, I believe that intervention with children of alcoholics is ultimately more difficult than with alcoholics themselves.

As the disease of alcoholism evolves in the family setting, it is most often treated as "the family secret." As family members become more compulsively involved with the alcoholic and his or her drinking or not drinking, they frequently become more and more isolated, as the family focuses more on itself and withdraws from other relatives, friends, and outside activities. It may or may not be verbally stated, but most family members feel alcoholism to be a stigma, a shameful thing. They comply with the code of behavior that says, "We will not talk to anybody outside the family about this." It is very difficult for a child in the family to break through this conspiracy of silence to speak up openly and directly about parental drinking problems.

In discussing intervention, we might first consider whether the intervention would be with the child alone, with the active addict, or with the family. I think you expect to discuss the former strategy. However, in my experience it is difficult to intervene with only the child in an alcoholic family if the parent or parents are still drinking. The parent(s) can usually prevent the child's getting help. After all, the parents pay for treatment and can usually impose their own restrictions on where the child can go and who the child can see. I've known many cases in which the active alcoholic parent prevented the child from getting help in any form, even though the child had been successfully "intervened with" and referred for help.

Intervention with the child alone if the alcoholic parent is in a recovery program is very easy. Simple "referral" is probably a better term than intervention. Involving the children in a family treatment approach to alcohol addiction is done easily and logically and is probably the best way to treat alcoholism.

There is considerable knowledge available about intervention with the active addict. The literature from the Johnson Institute is the best I have read. If the intervention strategy "works," i.e., the addict accepts referral, there seems to be little doubt that the family malfunctioning will diminish and the children will be helped. I suspect, however, this is not the topic I was selected to discuss.

I would assume that most of you here today are familar with

the Johnson Institute intervention technique. Briefly, in this technique family members and significant others prepare an objective list of concerns and problem situations that have evolved with the alcoholic. First in a rehearsed session, then with the alcoholic present, members of the group, one by one, out of their feelings of love and concern, confront the family member with their objective evidence of his or her drinking problem. In a *Ladies Home Journal* article, Betty Ford describes this type of intervention session that brought her successfully to the rehabilitation program for her drinking and drug problem. Now there is also an excellent new film by the Johnson Institute, called "Intervention," produced in Minneapolis, Minn., 1979, which describes and demonstrates this process.

So, intervention with the child could occur through this technique, if intervention with the alcoholic is successful. That is, if the alcoholic accepts the referral to treatment, the whole family can be intervened with and helped.

Now let us consider a different situation. A child living with a parent with an active drinking problem develops a behavior problem. For instance, the child runs away from home, attempts suicide, or becomes pathologically withdrawn. If this child is brought to a source of help (in Pittsburgh such a child would be brought to the Child Guidance Center) the *child* is the identified problem. Typically, the parents would be very unwilling to look at themselves as part of the problem or even as the cause of it. I am aware of several cases in which the therapist correctly attempted to focus upon the parents' behavior, especially their drinking behavior. In these cases the parents restated the premise that the child was the problem and consequently withdrew from treatment.

Another major problem that makes intervention with children of alcoholics difficult is a common role that the oldest child in an alcoholic family is liable to assume. This role, called in various studies by various names, can be referred to as the "Super Coper," "The Perfect Child Syndrome," or "The Family Hero." A child in this role tends to deny personal problems and to become the one who copes with whatever situation is at hand, trying to make the situation better. The child becomes capable of giving aid and help but has a difficult time assuming the role of the patient, i.e., the one with the problem.

Children in an alcoholic family, especially when young, are still dependent upon their parents for food, emotional support, and a protected environment. If they break the family secret

by talking about the problems at home, they are at risk, real or imagined, of losing their support system, their family. A few workers in the field of alcoholism have correctly said that children (of alcoholic parents) often divorce, separate, or otherwise break up. Sometimes there is even early death of the alcoholic parent, occasionally through suicide. Through any of these mechanisms, children are abandoned. The threat of withdrawal of parental affection and protection must be one of the most potent weapons that keeps children compliant with the family secret and prevents them from speaking out about it.

My present opinion is that the major problem in the treatment area for children of alcoholics is ignorance on the part of health-care professionals about alcoholism. They are ignorant especially about the family problems related to alcoholism, in particular those problems suffered by children. Thus, even if a child is intervened with successfully and makes it to a health-care professional, it seems to me highly unlikely that the health-care professional will be able to diagnose the nature of the child's and the family's problems and be able to work with those problems successfully.

It does seem to me, however, that it would be possible to intervene with the child if the child had trust in the person who was attempting to intervene. I think this person most logically should be a relative or close friend. If the relative or close friend is knowledgeable about the family dynamics of alcoholism, it is possible that he or she might be able to suggest to the child appropriate sources of help. However, I'm afraid that most of the time the trusted person doing the intervening knows little about the disease of alcoholism or how to make appropriate referrals.

Literature Review

To review the existing literature is, in my opinion, exceedingly easy. I know of nothing in the alcoholism literature that discusses intervention with children of alcoholics. There is, as I mentioned, a body of knowledge on utilizing the family members *and* the children in intervention with the alcoholic patient.

Alternate Approaches to Intervention

In assessing the major alternatives to intervention with children of alcoholics, I would say that intervention with the child as part of a treatment program for parental alcoholism is the most likely to succeed. Involving the whole family is certainly the

best way to treat the alcoholic and is a logical extension of intervention and treatment of the identified alcoholic family member. By seeing alcoholism as a family disease, the whole family is then an appropriate subject for treatment. This has been the approach taken by the treatment staff of the Johnson Institute in Minneapolis, Minnesota. This technique has the asset of a comprehensive family treatment approach, but has the liability that children whose alcoholic parents are not in treatment will be missed. I know the alcoholism treatment programs in Pennsylvania quite well. There is only one program I am aware of that attempts in any measure to approach the problems of children in a consistent manner. The often erroneous assumption made by the hundreds of other programs that do not involve the family is, I suppose, that if the alcoholic gets well the whole family will get well. Several reports, I believe, present evidence to the contrary; in spite of the alcoholic family member's recovery, many problems do continue in the children, problems that are eligible for intervention and treatment.

An alternative technique that might work, although I've not seen it in operation, would be a self-intervention arising from information, provided about family alcoholism as a disease. For instance, if a teen drop-in center had information about the effects of alcoholism on the family, teenagers might study the information, realize their own problems, and seek help. There might be help provided by some books that are available for children, such as *You and Your Alcoholic Parent,* by Edith Hornick, and the book soon to be published by Sharon Wegscheider, *A Second Chance.*

Another approach to intervention would be with peers. Perhaps one teenager active in Al-Anon or Alateen might approach a friend and intervene successfully if the friend were experiencing the same kind of problems. I know of a few instances in which this sort of intervention has occurred and has worked to a limited degree. The problem again is that the actively drinking alcoholic parent is going to prevent his or her children from reaching sources of help.

A different approach to intervention with children of alcoholics might be seen as a method of prevention. Henry Rosett, M.D.[1] in Boston has written about the successful intervention he has been able to accomplish with pregnant women in an Ob/Gyn

[1] Rosett, H.L.; Ouellette, E.M.; and Owens, E. The prenatal clinic: A site for alcoholism prevention and treatment. In: Seixas, F.A., ed., *Currents in Alcoholism 1.* New York: Grune & Stratton, 1977. pp. 419/430.

clinic. Here the pregnant woman is intervened with regarding her drinking problem even before the child is born. From Rosett's experience we have learned that the pregnant woman is amenable to this sort of intervention regarding her drinking. For the sake of her unborn child she may be more willing to give up her harmful drinking habits during pregnancy than at any other time. We probably will never know how many problems have been avoided by this sort of intervention strategy.

Research Needs

Further research is needed in how to intervene with children of alcoholics. I would like to see more experiments with peer-intervention techniques, either through Alateen members, their friends, or in a high school peer-counseling approach. Can the child be successfully intervened with while the parent is still actively drinking? Can an intervention strategy with the child of an alcoholic parent prevent the problems that are likely in later life? Further research is also needed, I think, in how to successfully teach the health-care professional about alcoholism and its effect on children in the family.

Children of Alcoholics: Treatment Issues

Charles L. Whitfield, M.D.

Who Are These Children?

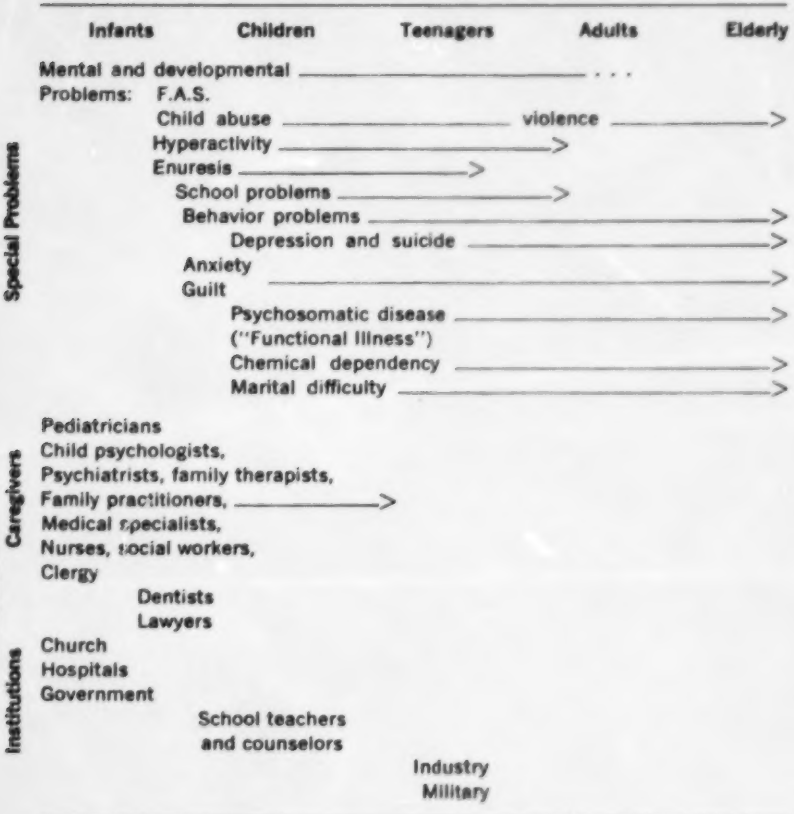
Who are the children of alcoholics? They are infants, children, and adolescents born to alcoholic parents (1–6). These children don't seem to resolve their problems when they become adults; rather, they carry many of them into early and late adulthood (7). They also transmit many of these problems to others, including their own children. Thus, the children of alcoholics include not only infants, children, and teenagers, but adults and even the elderly (see figure 1).

Alcoholism and Family Dynamics

Relationships within a family where there is active alcoholism are nearly always strained. The family members become unwitting enablers of continued drinking; sometimes these members are called "co-alcoholics" (8). They enable continued drinking out of care, concern, and love and out of a lack of knowledge (5). This enabling is accomplished by the unconscious use of the same involuntary mechanisms that are active in the alcoholic: denial, repression, projection, grandiosity, and others. This situation leaves family members in a state of chronic anxiety, sometimes with depression.

As more and more anxiety accumulates, so does anger. Unventilated anger eventually develops into rage. Anxiety and rage may, in turn, be handled in various ways, often with unhealthy and self-damaging results, though these results are almost always unintentional. Like all family members, the children of alcoholic parents also may develop all of these unhealthy coping behaviors (5–7). When they become adults, they exhibit many of these same problems.

Figure 1. Scheme showing children of alcoholics, some of their special problems in sequence, and their caregivers and influential institutions



Some Problems of Children of Alcoholics

What special problems do these people tend to have? The NIAAA study reported in 1974 a compilation of family problems, feelings, and outcomes as stated by 50 children of alcoholics after extensive interviews (7) (see table 1). We also know that these people tend to have certain problems at a higher incidence than the general population. Some of these problems are: fetal alcohol syndrome, child abuse and neglect, hyperactivity, enuresis, behavior problems, school problems, suicide, and chemical dependency. In addition, although unproven, they probably have a

Table 1. Family Problems, Feelings, and Outcomes of Children of Alcoholics

Family Problems	
Emotional neglect	Inconsistency
Family conflict (between parents)	Divorce/separation
Verbal abuse	Physical abuse to siblings
Family conflict (between parent and child)	Death of alcoholic parent
Nonfulfillment of parental responsibility	Instability
Child as parental confidant	Physical abuse to respondent
	Sexual abuse
	Physical neglect

Feelings		
Resentment	Admiration/respect	Protectiveness
Embarrassment	Confusion	Pain
Ambivalence	Guilt	Pity
Love	Disappointment	Abandonment
Anger	Rejection	Distrust
Hatred	Anxiety	Frustration
Fear	Helplessness	Defensiveness
Loneliness		Uncertainty

Outcomes		
Problems in relationships (opposite sex)	Lack of direction	Teetotalism
Leaving home early	Depression	Deadened emotions
Problems in relationships (same sex)	Underachievement	Running away
Lacking self-confidence	Alcohol abuse	Confused sexual identity
Young marriage	Suicidal tendencies or attempts	Drug abuse
Overachievement		Unwed pregnancy
Early independence/maturity	Feeling of being crazy	Promiscuity

higher incidence of the following: depression, functional (psycosomatic) illness, and difficulty relating to the opposite sex (5–7).

Perhaps the earliest problem some of these children may suffer is fetal alcohol syndrome (9), with its mental and developmental impairment as well as its burden to the family and society. Both of the latter already are burdened by alcoholism in general. Some people are now beginning to find adults with fetal alcohol syndrome (10).

The next special problem is child abuse and neglect (3,11–19). Included under child abuse are emotional, physical, and sexual

abuse. In one study of 51 abused children, 35 (69 percent) had a history of alcoholism or alcohol abuse in at least one parent. Of the 26 parents of these children, 24 (92 percent) reported that they had been abused by a parent who was alcoholic or abused alcohol. Although alcoholism has been pointed out to be a major factor in child abuse and domestic violence (3,11–18), many authorities continue to be ignorant of and/or deny such a causal relationship. This makes the abused child of an alocholic parent doubly denied. When abused children grow up to be adults, they often abuse their own children (11).

Hyperactivity (5,6,20–23) and enuresis (24) have been reported as common and special problems of the children of alcoholics. When I teach pediatric residents in training about alcoholism, including its effects on the children of alcoholics, they are surprised that school and behavior problems and depression and suicide may be seriously related to having an alcoholic parent (5,6). Because the children are consumed by guilt and feel responsible for all their families' problems, yet are too young to handle them, depression and suicide are common. It has been estimated that 80 percent of all adolescent suicides may be children of alcoholics.

In one survey 70 to 82 percent of adjudicated, delinquent adolescents were found to have at least one alcoholic parent. The surveyor found that out of loyalty or embarrassment the adolescents would not talk about their alcoholic parent. Furthermore, in not a single instance had an adolescent been referred to Alateen (25). Anxiety and guilt, then, often combined with shame and fear, are carried throughout the child's and adult's life.

In addition, many functional (psychosomatic) illnesses, both in childhood and adult life, may have as their major etiology being raised in an alcoholic family. Finally, the children of alcoholics are at high risk of developing chemical dependency (23–26). They are also likely to experience more than the ordinary difficulties relating to the opposite sex (6,7), which manifest themselves as marital difficulties.

Wegscheider (5,6) has described four common patterns among the children of alcoholic parents. These are the family hero, the scapegoat, the lost child, and the family pet. By studying more than 400 families in which alcoholism and other chemical dependencies were involved, she pointed out these childhood and subsequent adult patterns and described them in detail. (See table 2.) Many of these patterns and problems are discussed

Table 2. Four Problem Patterns in Children of Alcoholics [1]

	Visible	Feels	Family Focus	Characteristics	Future	
					Without Help	With Help
Family Hero	Does what's right Successful	Inadequate	Proud	High achiever	Workaholic Never wrong Responsible for everything Marries dependent (Chief enabler)	Learns to relax Accepts failure Responsible for self
Scapegoat	Angry Defiant	Hurt	Scapegoat for alcoholics	Won't compete Acts out	Delinquency Unplanned pregnancy Trouble at school and office	Accepts responsibility Becomes good counselor Ability to see reality Improvement

t Child	Withdrawn	Lonely Unimportant	Relief (not a troublemaker)	Quiet Follower Difficulty making decisions	Little zest for life Sexual identity problems No long-term relationships Bedwetting Questionable psychosis Often dies young	Independent Talented Creative Imaginative
mily Mascot	Immature Fragile Needs protection	Fearful	Comic relief	Anxious Hyperactive Learning disabilities	Compulsive clown Can't handle stress Marries hero for care Chemical dependency	No longer clown Handles stress Fun to be with Good sense of humor Improvement

dapted from Wegscheider (5,6).

above. Others not discussed, but needing mention, are workaholism, sexual identity problems, and early death.

Who Are the Caregivers?

The givers of care to the children of alcoholics come from many backgrounds and specialties. First, there are those caregivers who work in family planning. Then there are several kinds of medical specialists, including obstetrician-gynecologists, pediatricians, family practitioners, psychiatrists, nurses, nurse-midwives, and others.

The child also may encounter the clergy, child psychologists, family therapists, and social workers, as well as dentists and lawyers. Finally, in school, as adolescents, and throughout their adult life they will be supervised by school teachers and professors, as well as trainers, supervisors, and bosses of all sorts.

The words "caregiver," "helper," "teacher," "physician," and "therapist" all imply that help could be rendered. But why is help not presently being rendered? Or if it is being rendered, why is it so often directed at the symptoms and not at the condition that some have called "co-alcoholism"? (6,8) One possible answer is that the caregivers themselves have the same condition, i.e., enabling or co-alcoholism, as the very people they want to help. That is, the helpers themselves are denying, covering up, and perpetuating the disease of alcoholism in an enabling or co-alcoholic fashion (6). If this is true, then it is a basic and serious treatment issue for the children of alcoholics.

Which Institutions Care for the Children of Alcoholics?

Institutions that care for the children of alcoholics include organized religion, hospitals, government, miscellaneous offices, schools and universities, industry, and the military. Outdated social policy runs most institutions, and the staff follow that policy. It is the people who run these institutions who ought to be addressed regarding any treatment issues for the children of alcoholics.

What Is Appropriate Treatment?

What would be appropriate treatment for the child of an alcoholic? My suggestion is that appropriate treatment would in part depend upon the development life stage of the individual.

For the unborn child, the family planner, physician or nurse-midwife, or any caregiver prior to conception of the child, should identify the mother's (or father's) drinking problem and initiate treatment or referral. This action likely would prevent part or all of fetal alcohol syndrome (9,27).

For an infant or young child, appropriate treatment would also consist of recruiting the actively alcoholic parent or other family member into treatment (6,28,29). Work with the most functioning member of the couple or family may begin to change the overall family system. For this and other reasons I strongly believe that a nonalcoholic family member ideally should be recruited into regular attendance at Alanon meetings, with appropriate individual treatment and followup. The most ideal person for Alanon would be the nonalcoholic parent.

In working with an active alcoholic person, one cannot treat the whole person until the toxic alcohol is removed. Thus, a major emphasis in treatment of the actively drinking alcoholic is in the motivation and maintenance of abstinence. It also may be difficult to treat the children until the "toxic agents," i.e., the parents, are treated themselves. While treating the children is appropriate at any time, such treatment will be far easier if the parents are recovering. Some workers do not see children unless their parents are also in treatment (30).

The Importance of Recognition and Trust

A similar treatment approach could be used for older children. When they are old enough, pre-Alateen attendance would be appropriate and likely beneficial. However, it is very difficult to "prescribe" Alateen or pre-Alateen for children of alcoholics. Trust is a highly important factor here. If both the child and parents cannot trust the caregiver, the child is likely never to reach appropriate treatment.

Recognition also is important. Most children of alcoholics, especially up to and often through the teenage years, do not realize that their family's problem is alcoholism (28). Thus, it is essential that every caregiver recognize the problem and establish rapport with the patient and the family. This may be one of the most difficult tasks in all of the helping professions. A major reason why caregivers tend not to recognize and provide appropriate treatment for these problems is their lack of training. I believe this lack is due largely to a general denial and ignorance (discussed below) by all of us.

If child abuse is present (3,11–19), then the parents should be

treated by a caregiver with expertise in child abuse. Part of this treatment should be to encourage or require attendance at Parents Anonymous meetings. Parents Anonymous is for the parents of abused children, and alcoholism seems to be a common problem among attendees.

Appropriate reading for children and teenagers (13,31,32) and adults (1,33) may be helpful. It should be readily available in the offices of all caregivers. There is also an excellent film available (34) that may be helpful to children, their families, and untrained caregivers.

Family members themselves may choose to have individual or family therapy (35,36). If a family therapist is chosen who has skills in working with families of alcoholics, then therapy is likely to be successful. The local council on alcoholism may be helpful in locating such a family therapist. Family members often consult crisis centers, but do crisis centers have the tools to help? If not, what is missing?

When the child grows into an adult, Al-Anon would be the most appropriate form of treatment. For best results, Al-Anon should be combined with individual, group, and/or family therapy. Any of the above appropriate treatments probably should be ongoing for at least several years to allow the child or adult to receive maximum treatment.

For treatment to be appropriate, caregivers should be trained by experts and teachers in the alcoholism and drug abuse fields. This training should be given throughout the undergraduate, graduate, and postgraduate years with a substantial number of curriculum hours. Interdisciplinary teaching and innovative ways of learning need exploration. For example, at the University of Maryland School of Medicine we have started an informal therapy-supportive group for students, faculty, and staff who have an alcoholic family member. Other professional schools may choose to try such a group.

What Is Blocking Appropriate Treatment?

From a survey that I have conducted of six health professionals with expertise in the area of children of alcoholic parents, it seems that less than 5 percent of the children of alcoholics are being appropriately treated. What factors might be blocking such treatment?

I believe that the two most important reasons are in all of us: denial and ignorance. In a cyclical fashion, these two factors shape social policy and practice in the health-care system (see figure 2).

Figure 2. Scheme of some factors blocking appropriate treatment for the children of alcoholics

A. *Denial*

Denial is a part of the illness of both alcoholism and co-alcoholism (see also "Alcoholism and Family Dynamics," above). This denial may be due to a number of reasons, one of which is need of a defense against pain, usually unbearable pain. The effect of the denial is to palliate some of the individual's suffering. There are many reasons for and causes of this denial (37). Some of these are:

- lies
- protective denial
- blackouts
- euphoric recall
- no one identifies problem
- wishful thinking
- denial on part of family and other close people, including helpers
- ignorance of what an alcoholic is (38)
- thinking quandry (39)

These are the same factors of denial that the alcoholic uses, and this denial is unconscious (8,7,39).

Alcoholism and chemical dependency may be common in the families of health professionals. I have surveyed four medical school classes in two different universities and have found that

a minimum of 37 percent had a parent or other close family member with alcoholism or chemical dependency. I also have surveyed medical students taking substance abuse electives and have found that from 50 to 100 percent had the problem in their family of origin. Although research is necessary in these areas, we may be able to extrapolate these findings to other health professionals. If many of us have the disease in our families, then it is likely to be a major reason why we are unsuccessful, frustrated, and bewildered in treating our alcoholic or co-alcoholic patients. I believe that this problem is a major treatment issue for the children of alcoholics.

Denial also functions to protect the alcoholic's right to drink and the right to attempt to control the alcoholic for the enabler or co-alcoholic.

The following are examples of this denial in our society:

- At a recent national convention for child abuse and family violence, several of the major speakers claimed that alcoholism and other drug abuses were not major factors in child abuse.
- On a recent national television 1-hour documentary on child abuse and neglect, as well as on a half-hour local Maryland follow up panel discussion, there was not a single reference to alcoholism being related to child abuse.
- There are countless examples from fiction and nonfiction literature describing problems of the children of alcoholics. Perhaps the most popular recent one is a book called "Mommy Dearest" by Christine Crawford about her mother, Joan Crawford, the movie star. I have seen this book discussed on a major television talk show by the author and a large audience. I have also spoken with several people about it. Despite the fact that most of the child abuse described in this book occurred when Joan Crawford was drinking heavily, no person that I have spoken with made the connection.
- In several recent popular talk shows on television discussing chemical dependency and delinquency among teenagers and children, the possibility of alcoholism or other chemical dependency in the family was never mentioned.
- Finally, at a recent major department meeting in a school of medicine, the film "I Never Sang for My Father" was shown in synopsis form. To me it was clear that the grandfather's drinking problem was a major factor in the psychopathology of his son, which he then transmitted to his own son and daughter. No one in the department made the connection, and I did not point it out to them.

I believe that denial by all of us is a major treatment issue for the children of alcoholics.

B. *Ignorance (Lack of Appropriate Training)*

Ignorance or lack of appropriate training is, in a way, part of the denial. It may be personal, that is, with the child of the alcoholic. It may also be with the caregiver, but in the latter case it seems to be a lack of appropriate training. From physicians to nurses to the clergy, caregivers generally are not taught about the recognition, diagnosis, and appropriate treatment and followup for alcoholics and their families. Only one in three medical schools and fewer nursing and other schools have even the beginnings of an appropriate training program in alcoholism and drug abuse (39). Even at my own institution, which is presently among the best in the country in teaching about substance abuse, the students and residents-in-training receive only about half of what we estimate they need to help an alcoholic or family member satisfactorily.

There is presently little ongoing research in the treatment of alcoholics and their families. This is especially true when compared to the research in other medical disciplines in such areas as cancer and heart disease.

I believe that denial and ignorance, i.e., lack of training, are probably the most important treatment issues for the children of alcoholics. Other people who may block appropriate treatment for the children are other family members, some of whom may be alcoholics or chemically dependent themselves. The fact that the original addiction has not been dealt with is often crucial.

C. *The Oppression of Children*

Finally, and perhaps equal in importance to denial and ignorance as a treatment issue, is the general oppression of children including the treatment of children as possessions more than as individuals. In the past few centuries people in many countries have become liberated as voters. Slaves have become liberated. And women have been liberated and are continuing to liberate themselves. There is even talk of men becoming liberated. But I hear little or no talk of children's liberation.

Summary of Some Major Treatment Issues

- Most caregivers are themselves enablers or "co-alcoholics" (5, 6,8,36).
- Almost all caregivers—to some measure—deny or are ignorant

of alcoholism, thereby feeding the vicious cycle of failing to recognize alcoholism and giving inappropriate treatment (6, 8,38,39).

- There is a lack of innovation and research in education and treatment in this area (19,41,42).
- It is difficult to engage the child and the parents in a trusting relationship for treatment.
- The parents usually are not involved in appropriate treatment.
- Children are still generally oppressed in most of our cultures.

What Can We Do About These Problems?

How can we in the alcoholism and the broader pediatric fields deal with the denial and lack of skills among our colleagues and others? I believe there are at least eight possible ways of dealing with these problems.

- Be a role model. In our daily practices and consultations we all can treat children of alcoholics appropriately (see above for suggestions).
- Educate. We can begin motivating actions that will prompt serious exposure of the faculties and students of our professional schools to this problem and how to deal with it.
- Screen for the problem. For example, we could give the Michigan Alcoholism Screening Test (43) to the parents of all children presenting the above enumerated problems in addition to taking a comprehensive family drinking history.
- Confront enabling or co-alcoholic behavior (5,6,8) in family members and, where appropriate, confront the family member with the fact of alcoholism or chemical dependency (44).
- Offer hope. This is a major way of breaking down the strong denial part of the enabling process (1,31,32,33).
- Empathize. This likewise will break down denial (44).
- Use employee-assistance programs. These industrial programs for the recognition, referral, and treatment of impaired job performance, which is most commonly caused by alcoholism and other chemical dependency, often have a family component. The latter most often consists of involving the spouse in Al-Anon or similar treatment, which will indirectly help the children, often in a major way.
- Publish observations and findings in refereed journals. This action gradually will call attention to the importance of recognizing and appropriately treating the children of alcoholics.

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Prevention Issues Involving Children of Alcoholics

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Introduction

The purpose of this paper is to explore primary prevention issues in working with children of alcoholics. Although the paper is limited in focus, this limitation does not mean that children are the only appropriate targets for primary prevention. Alcohol-related problems including but not limited to alcoholism also will be considered. Consequently, the theme of this article is that primary prevention of alcohol-related problems in the offspring of alcoholics is possible, although not necessarily easy.

What is primary prevention?

After 2 years of deliberation, the National Council on Alcoholism in 1976 defined primary prevention as follows:

"Primary prevention of alcohol misuse, abuse, and alcoholism means to permanently forestall the development of these conditions."

This definition carefully avoids the controversy of whether alcoholism is inherited and avoids the problem of whether the "prevention" is permanent by the use of the word "forestall." Perhaps in large measure because it circumvents these issues, this definition of primary prevention has received widespread support and has directed the attention of professionals in the alcoholism field to the possibilities of primary prevention.

The definition used in this paper, however, will be my own:

Primary prevention of alcohol-use-related problems—is the combination of policies and strategies, including interventions, designed to redirect, eliminate, or reduce the impact of etiologic and intervening variables.

The following explains key language found in this definition:

- "policies" means explicit and/or implicit rules, regulations, and laws that affect access of beverage alcohol such as: legal age of purchase, hours of sale, 40-hour work week, and 55 miles per hour speed limit.
- "strategies, including interventions," means programs or activities directed at the individual or group of which the individual is a member such as: homogeneous small group discussion, heterogeneous after-school activities, anticipatory crises intervention, and sessions with a counselor.
- "etiologic and intervening variables" means potential predisposing factors that, when found singly or in combination, contribute to the development of disease, illness, injury, accident or negative consequences. These factors may be found within the individual in the form of genetic code and personality constructs or in the environment in the form of number and proximity of alcohol distribution outlets, poor travel conditions, and relative fireproof safety of bedding.

High-risk groups are, therefore, subgroups of the general population who, due to specific criteria, risk developing a specific disease, accident, injury, or other negative consequence. At-risk or high-risk groups occur:

- Longitudinally when, due to a genetic characteristic, familial pattern, or long-term behavioral pattern, in series or combination, an individual has greater potential for the development of an alcohol-related illness, disease, accident, injury, or consequence.
- Transitionally or situationally when, due to a temporary or short-term occurrence, an individual is considered to have a greater potential for the development of acute alcohol-related problems such as an injury or other negative consequence. (It is important to note that the result of this risk status can be a long-term event such as an injury sustained in an alcohol-related car accident. The time for which they are at risk is short; in this instance, the time they are in the car.)

The Case for Considering Children of Alcoholics as High Risk

As can be surmised, children of alcoholics constitute a unique group because they are at risk for both long-term and short-term problems. This section discusses the type of problems they most often experience and examines research themes under the general areas of health, mental health, and alcohol-related problems.

Selected articles are reviewed with regard to their themes, assessing areas that necessitate primary intervention. For the most part, studies that found conflicting results are not reviewed due to their bias that there is no "one profile" of the child of an alcoholic. Only brief reference is made to methodologies employed for sampling, control group, and even statistical analysis. On the whole, however, most samples can be characterized as "convenience" as opposed to "representative," and most sample sizes are small. This presents difficulties in validating clinical impressions, but presents less of a problem in outlining target areas for intervention.

A. *Health Issues*

In two early independent studies, children of alcoholics were not found to have physical symptoms different from children of nonalcoholic homes (Nylander 1960; Chafetz et al. 1971). However, later studies did find health differences between children of alcoholics and nonalcoholics.

Hyperactivity. Morrison and Stewart (1971), in a study of 59 hyperactive children, found that 20 percent of their fathers and 5 percent of their mothers had alcoholism—which led them to confirm a hypothesis that hyperactivity may be inherited. Cantwell (1972), in a similar study, found 4 percent of the mothers and 15 percent of the fathers in his group of hyperactive children had alcoholism.

Although these figures are high, Goodwin et al. (1975) believes these findings may represent underestimates of the level of hyperactivity found in children from alcoholic homes because many hyperactive children also display antisocial behavior. For this reason a diagnosis of hyperactivity often is not made.

Child Abuse and Neglect. The relationship between alcoholism and child abuse has been reported frequently by clinicians, but does not appear as often in the extant literature. In 1964, Krimmel and Spears commented on the frequent outbursts of violence in families with alcoholism.

Keane and Roche (1976), in their study of children of alcoholics, found more symptoms in children from alcoholic homes where a physical assault had occurred by the alcoholic against a child or spouse. One study found alcoholism a factor in 65 percent of cases of hospitalized battered children and in 82 to 90 percent of cases in the French social agency and juvenile justice system (Mainard et al., 1971). But this finding does not

confirm all the findings from other studies made at that time. A study in Great Britain found that alcoholism was less important a factor in child abuse than parental psychopathology (Smith et al., 1973).

As research begins to focus on the relationship of child abuse and neglect to alcohol use and abuse, it appears more and more that alcohol use serves as a facilitator of child abuse. For example, during the stages of alcoholism when there are frequent explosive, alcohol-related outbursts, abuse of alcohol appears to be correlated with child abuse. One explanation of this is that the child literally has not learned to get out of the way of the alcohol-abusing parent. By the time alcohol-related violent outbursts become more frequent, the child may learn the cues and go to his room or to a neighbor, not come home at all, run away, or call the police. At this point the child may no longer be physically abused but the outstanding feature of this home may become child neglect as the parents' involvement with each other escalates and time for the child diminishes (Mayer and Black, 1977). The study of the relationship of child abuse and neglect to alcohol abuse and alcoholism recently reported by Behling (1979) stated that 69 percent of the cases referred for child abuse and neglect fell into this category.

Research in this area has also suffered from poor definition of key terms—child abuse and neglect, alcohol abuse, and alcoholism—and from the reluctance of the child-abuse and alcohol-abuse fields to share information. However, as this area is scrutinized more closely, a pattern is beginning to emerge in which alcohol use is clearly a facilitator of that abuse, unless the child has learned "to get out of the way."

Fetal Alcohol Syndrome. The major health problem from which children of alcoholics may initially suffer is the fetal alcohol syndrome (FAS). The outstanding physical features of this syndrome are prenatal and postnatal growth retardation, cranial deformities, central nervous system damage manifested by intellectual or behavioral abnormality, and possible abnormalities in other systems (Clarren and Smith, 1978).

Recent attention also has focused on alcohol-related birth defects. These defects, while not considered to be FAS, still merit concern. They include limb abnormalities, cardiac defects, and learning difficulties (Rosett, 1976).

Although this area is filled with controversy, it is becoming clear that for some women there is a negative relationship between alcohol use during and perhaps prior to pregnancy. It is

not yet clear what contribution a male's heavy drinking has on conception and subsequent fetal development.

B. *Prevalence of Alcohol-Related Problems in Children of Alcoholics*

There seems to be a clinical consensus that children of alcoholics tend to develop alcoholism and alcohol-related problems, yet this area has attracted scant attention from the research community.

Drinking Practices. Goodwin and Guze (1974) report that retrospective studies in 1929 found that (of over 1,000 alcoholics studied) alcoholism occurred in 53 percent of the fathers and only 5 percent of the mothers. In 1933, Pohlisch's findings were similar; 47 percent of the fathers of alcoholics he studied had alcoholism. A more recent retrospective study by Goodwin et al. (1973) found that children of alcoholics were twice as likely to develop an alcohol problem as were children of nonalcoholics.

Lindbeck (1971) found that sons of alcoholics used alcohol as a problem-solving method. Over one-third of Cork's (1969) sample of 115 children intended to drink at some point in the future; only 5 were currently drinking. Rouse et al. (1973) studied adolescents 15 to 21 years old—sons and daughters of heavy-drinking parents—who reported more depression and loss of control over anger although their drinking habits did not differ from the habits of those adolescents whose parents were not heavy drinkers.

McLachlan et al. (1973) investigated the drinking practices of children of recovered and unrecovered men and women. Oddly enough they found that children of unrecovered alcoholic parents consumed the least amount of alcohol.

Choice of Spouse. Little research has been conducted on the choice of spouse by a child of an alcoholic, although it is a common assumption that the daughter of an alcoholic will marry an alcoholic. Clifford (1960) found that all the wives in his study of alcoholic marriages came from homes with a history of alcoholism. Bailey et al. (1965) found "unnatural" attitudes toward drinking by parents of wives of the alcoholics studied. Of these parents, 79.2 percent either drank excessively or were totally abstinent.

C. *Mental Heath*

The bulk of research on children of alcoholics has focused on their mental health problems. Many of these studies appear to

have been attempts to understand the effects on children of the inconsistent and chaotic nature of most alcoholic homes.

Psychosomatic Complaints. Nylander (1960) found that children of alcoholics were more likely to be admitted to inpatient and outpatient care complaining of ills for which no organic cause was found. Girls complained more of stomach pains, anxiety, fatigue, and sleep disorders. Boys experienced more speech disorders, hyperactivity, and bowel incontinence.

Self-Concept. Few studies actually have investigated the self-concept variable. Those studies were done by either comparing children of alcoholics to a control group, or by comparing children of active alcoholics to children of recovered alcoholics. The following two studies found different results, raising some interesting questions. McLachlan et al. (1973) found that in comparing children of active alcoholics to those of recovered alcoholics, children of recovered alcoholics had the lowest self-concept of all groups. O'Gorman (1975) found that adolescents from active problem-drinking homes had the lowest self-concept when compared to adolescents from recovered alcoholic and nonalcoholic homes. Aside from methodological variations, part of the difference between these two studies may be explained by the fact that the maximum length of sobriety in the McLachlan study was 2 years, while the minimum length of sobriety in the O'Gorman study was 3 years.

Antisocial Behavior. Robins et al. (1962) found that children from homes with a pattern of excessive alcohol consumption and social deviance tended to develop these same patterns as adults. MacKay (1961) found that 16 percent of his sample of delinquent boys came from alcoholic homes. Bailey et al. (1965) found children of alcoholic homes more likely to be known to correctional facilities. Fine et al. (1975) found in a study of children of alcoholics under age 13 that this group had significantly more social aggression. The Booz-Allen and Hamilton (1974) study named "flight" as one of the four coping mechanisms used by the child of the alcoholic.

Psychological Profiles. The following studies outline several aspects of psychological and familial functioning:

- A study by Hecht (1973), while noting familial inconsistency as a major problem within the alcoholic home, also noted that the more well-adjusted child of the alcoholic may experience rigidity, the need to dominate, and a need for perfection.

NIAAA (1974) also found two types of coping styles in the better adjusted child of the alcoholic: the "good" child who is passive and does well in schol and the "super-coper," the child who literally organizes the family and attempts to keep it together. However, the most common coping style was "flight," be it emotional, intellectual, or physical. Lindbeck (1971) found poor school performance and attendance a characteristic of children from alcoholic homes.

- Cork (1969) found many children from the alcoholic homes she studied to be socially isolated, with marked tension and competition between the siblings. Kearney and Taylor (1969) found that adolescents from alcoholic homes were more likely to be suicidal, act out, experience legal problems, be institutionalized, and have more serious psychiatric diagnoses. Aronson and Gilbert (1963) found sons of male alcoholics dependent and evasive of unpleasant situations.
- Fine et al. (1975) found children of alcoholics under 13 years old more dependent, socially aggressive, and emotionally detached, and they exhibited a more pathological use of the senses. Adolescents, on the other hand, were found to think more paranoically and behave more unethically.
- McLachland et al. (1973) found that adolescents from active alcoholic homes were significantly less close to their fathers than normal and, when asked, responded that they would like to have had different fathers. Sons of alcoholics saw their families as less cohesive than nonalcoholic families, although subjects with alcoholic mothers did not express this view.
- O'Gorman (1975) found that adolescent children of active alcoholics had a significantly more external locus of control than did those of nonalcoholics and were significantly more external than were those from recovering alcoholic homes. Adolescents from active alcoholic homes also perceived significantly less love and affection coming from their fathers than did those from nonalcoholic homes. Adolescents from recovering alcoholic homes perceived more demands upon them than did those from nonalcoholic homes.

D. *Sex Differentiation*

In studies that investigated male and female children of alcoholic parents, few sex differentiations were found. Unfortunately, there has been inadequate attention to studies of this type. The Keane and Roche (1976) study was one of the few

to find any differences; namely, that male children of alcoholics experienced more symptoms than female children.

Primary Prevention Overview

Despite historical and recent attention devoted to primary prevention of alcohol problems, it has been argued that chronic diseases such as alcoholism cannot be prevented because of their unknown etiology. Such linear thinking, while appropriate for infectious diseases such as parasitic ones where there are single causes, is not appropriate for chronic diseases.

The dominance of an infectious disease model in primary prevention schemes is understandable when one realizes that until recently, infectious diseases were the leading cause of death. As total populations were at risk of developing a single disease, prevention strategies evolved that dealt with identifying a single agent and isolating populations from the consequences of that agent, such as in immunization programs (Nightingale et al., 1978). Unfortunately, the current dominance of this scheme of prevention in the alcoholism field has resulted in a debate about the feasibility of primary prevention.

The problem with an infectious disease approach to the primary prevention of chronic diseases is that it ignores the nuances characteristic of these disease types, which, in turn, are keys to their prevention. Since chronic diseases are not evenly distributed throughout the population, and since everyone does not share the same risk of developing one or more of them, a risk concept is needed as a beginning point for prevention efforts. Determining the risk groups for each chronic disease and assessing the magnitude and duration of these risk groups are important.

In a historic document, the Institute of Medicine indicated that one of the difficulties in chronic disease prevention is that the causes of the diseases frequently include a variety of components—genetic, environmental, and behavioral—and many of these components are the potential targets for preventive efforts. However, chronic disease prevention may mean restricting the lifestyle of a "symptomless" individual in order to reduce his or her potential risk of developing a specific disease (Nightingale et al., 1978). In the case of alcohol, seen by many as part of the "good life," motivation to restrict its use becomes a prime consideration, giving added importance to the identification of who is at risk.

It is important to note the multiplicity of factors that cause

an alcohol-related disease—illness, accident, injury, or negative consequence. As a result, multiple factors also must be included in primary prevention. This concept strongly implies the need for a high risk categorization of individuals at risk. Due to the variety of predisposing variables, one might encounter different risk levels, each of which should be addressed with an appropriate prevention scheme.

Primary prevention is therefore a concept based on risk groups. This is particularly true for problems related to alcohol use, chronic problems for which everyone is not equally at risk. Acute (short-term) problems tend to be more evenly distributed as more individuals use alcohol and perform certain tasks; yet certain groups will be more at risk for certain problems than others. Longitudinal groups may be at risk more often for certain acute problems and are a subpopulation of those at risk for the same acute problems.

Before we discuss primary prevention approaches, it is important to distinguish a primary prevention approach from informational or educational approaches. There are basically two approaches to the prevention of problems related to alcohol use.

The first approach focuses on the changes in the social and environmental conditions threatening health. This focus represents one that is outside of the person and, in the alcoholism field, concentrates upon the forces that impinge upon that person, such as availability of alcohol in terms of hours of sale, density of package stores, price of alcohol, personnel practices that sanction drinking during lunch, and the safety of certain products. Action in any of these areas should take the form of a policy initiative.

The second prevention approach focuses on individual behavior. This approach may take three forms:

- Development of avoidance or control behaviors, for example, not drinking in certain situations, such as before driving, keeping to a two-drink limit per occasion, or monitoring the physical effects on the alcoholic (Strauss, 1976)
- Strengthening existing positive behaviors, for example, the serving of food and nonalcoholic drinks during a party
- Engendering new behaviors, for example, relaxing while playing sports and not just while drinking

On a programmatic level, primary prevention seeks to achieve a behavioral or consequential outcome based on some information and education. This distinguishes it from information programs, which have a purely knowledge-retention outcome, and educa-

tion programs, which use facts to affect values but do not necessarily go beyond this process to affect behavior.

Prevention Approaches

From the review of the three risk areas, alcohol-use problems, health problems, and mental problems, it is apparent that children of alcoholics are at high risk for a variety of reasons. The question that arises is, "Which of these areas is of primary concern to a particular child?" On an operational level the question then becomes, "What are we going to prevent and in whom?" This is a necessary question because it is unlikely that one approach will cover the full range of potential problems. Therefore we must begin to discuss prevention in specific terms. Below, prevention will be discussed from the perspective of individual behavior. Then prevention approaches will be discussed in the context of the specifics of each risk area. Prevention approaches discussed in one area are not assumed to be operative as a precondition to those in the area following—that is, a prevention system is not assumed to be in place for which each approach is an example. While that might be the ideal case (one that should be seen as a goal), it is not usually found. Therefore, when such areas as child abuse are discussed, the approach mentioned does not include prevention of resulting mental health problems.

The question of prevention specificity can be decided on:

- A systems level. An example is the decision on the part of an adult treatment facility to include the children of their patients in a prevention program, or the inclusion of special services for this population as part of a broader prevention program. The CASPAR program is a noteworthy example of the latter.
- An individual level. An example is the concern by a teacher for a particular student.

Action on both levels needs to be based on an understanding of the child, the basic characteristics of the home (for example: Is the parent still drinking? Is the parent sober? How long has the parent been sober?), and the various approaches possible.

Primary prevention theory is not necessarily difficult; in fact, as one "sage" said, "The really difficult things to grasp in life are the simple ones." So it is with prevention. Although the concept is not complicated, the approaches often are, especially when we view the potential for a specific problem's development not only within the framework of individual dynamics but also within its natural context. For example, the use of alcohol by

adolescents, in general, is expected by peer and reference groups and, as such, is considered "normal." When we try to inform adolescent populations about their particular risk if they partake in "normal" activities, we can run into difficulty. Following the wise words of the 1978 Institute of Medicine Conference on Adolescent Behavior and Health, we need to develop "educational material and approaches, services, and programs pertinent to adolescent health . . . to be tailored carefully to the cultural background, developmental stage and environment of the target population"; in our case, children of alcoholics.

Therefore, the challenge for prevention approaches that deal with children of alcoholics is how to tailor them not to stigmatize the child and to help the child develop appropriate coping mechanisms. A word about stigma. In my opinion, concern about stigma often becomes an excuse to do nothing. Many children of alcoholics are known in their schools and communities because often it is difficult to keep the "happening" within the family a secret. Therefore, many people know of the problem but either pretend they do not—"the big secret everyone knows"—or are afraid of dealing with the consequences and block out information that would prompt action. These children are stigmatized in a most insidious way: by having a problem no one will address. If we address this issue directly, much of the stigma will be reduced. This is not to say that we should have rap groups for these children in schools with a sign on the door letting everyone know who's attending. But it also does not mean that we should do nothing for fear of doing something wrong. The provision of specialized separate and specialized integrated services is crucial.

In my opinion, children of alcoholics must be assisted in coping with what they already know, namely that their families are different in some ways, and that they may develop an alcohol-related problem. By addressing their fear of, "Can it happen to me?" by saying, "Yes, but not if you . . . ," we can minimize the development of problems and prevent others from starting. Unfortunately, as a society, we have avoided giving a straight answer to their questions. Therefore, as we ignore and even deny the existence of a potential problem, we assist the child in the same denial.

A. *Prevention of Problems Related to Alcohol Use*

For the child of an alcoholic, denial of potential problems in earlier years creates other difficulties. An example is problems related to the use of alcohol.

I have been struck by how easily some pre-schoolers from alcoholic homes will answer, "What do you want to do when you grow up?" by indicating, sometimes in great detail, whom they will marry, where they will live, and how many children they will have, and concluding with the statement that they won't drink, and that their intended will feel the same way. In contrast, adolescent children of alcoholics are often known to go out to a bar and continue their Alateen meeting over a "few," while some Alateen sponsors wil proudly announce the "graduation" of an Alateener into AA. (This comment is not meant to be a condemnation of Alateen, which continues to be the only viable local resource on the community level. It merely points out a consideration for Alateen that other sponsors are taking to heart.)

With evidence mounting that offspring of alcoholics are the most likely to develop an alcohol-use problem, it would be wise to encourage children of alcoholics not to drink at all; after all, there are people who cannot drink milk, eat chocolate, tolerate sugar, or even fats. We must begin to consider why we often are reluctant to take this dietary control approach to alcohol for this high-risk group. If the offsping of alcoholics decide to drink at any age, we must at least encourage them to monitor alcohol's physical and psychological effects upon themselves. One technique to achieve this is given by Robert Strauss. Strauss (1976) makes a convincing case for applying techniques used in drug research to the treatment and prevention of alcohol-use problems. Strauss suggests that the subject write down thoughts and feelings about the day's events in a daily diary. The diary also could record alcohol usage: how it is used, its initial physical effects, and its later physical and emotional effects. As part of a general health education program this approach might create problems, but it easily could be combined with Alateen, family counseling, or a coping skills group designed specifically for children of alcoholics.

This same concept of addressing directly the risks of alcohol consumption also could be used in values-clarification exercises that seek to have their participants arrive at "responsible decisions." The issue involved is not only shaping attitudes and perhaps behavior, but also shaping "intention to use."

Although experts felt that behavior change based on values-oriented education are no more useful than those based on changes in knowledge and attitudes, the key to any of these approaches lies in the clear definition of a target group. As has been discovered with heart disease, behavioral messages directed

to specific, self-identifying populations can be effective (Stern et al., 1976). By clearly defining children of alcoholics as at risk for developing problems related to alcohol use, we can begin to target them with behavioral images.

The use of this suggestion presupposes that professionals concerned about this issue will be willing to "take the risk" of calling these children at risk and to speak about the specifics of their alcohol consumption; that is, to indicate that they should not necessarily try to drink like "others."

This concept, supplemented by students' being helped to establish a peer group sympathetic to their decision on alcohol use and assisting their integration into a supportive network, should prove to be valuable. Because primary prevention, by its very nature, is targeted toward a "symptomless" audience, there are problems associated with this approach, one of which is the normal phenomenon of "youthful invulnerability." For this reason, the earlier certain models of behavior can be delivered and reinforced, the greater their chances for success.

B. *Prevention of Health Problems*

Fetal Alcohol Syndrome. The fetal alcohol syndrome (FAS) is considered the most preventable of all leading causes of birth defects. There is currently much speculation as to how much alcohol is a safe amount to consume prior to and during pregnancy for both males and females. Some researchers advocate total abstinence. Prevention approaches for FAS will of necessity concentrate on warnings about alcohol consumption. Until such time as high-risk groups can be determined, the message to all men and women during their fertile years may be, "The safest decision is not to drink at all." The placement of such messages is important. Aside from the usual suggestion to include in school curriculums, having this message well integrated into the media will be important. There is already some indication this is beginning to happen. Such messages may also have a spillover effect for the children of the alcoholic and could reinforce their attempts to critically view their alcohol consumption patterns.

Child Abuse and Neglect. The prevention of child abuse and neglect is a complicated issue involving the parents' learning new methods of disciplining children and of relieving tension, and the child's learning to perceive the signs and "get out of the way."

Prevention of child abuse in alcoholic families calls for cooperation and understanding on the part of alcoholism treatment

units, child abuse treatment teams, and other related agencies such as runaway networks and youth agencies. Through recent Federal efforts we are drawing closer to this kind of cooperation and understanding. Incorporating parenting skills as part of alcoholism rehabilitation programs must be a prime consideration. Training educators, youth workers, and mental health workers to recognize the early signs of child abuse and neglect and to take necessary action also is important.

One of the most overlooked strategies is actually working with children to teach them to learn the pattern and perceive the signs of forthcoming abuse. They learn to leave the situation by going to a neighbor, staying in their room, running away, or not engaging the parent—in short, the children learn to "cope" with the situation. For one Alateen group in New Jersey coping became a major issue, and the group developed a child abuse manual for children (Perrine, 1979).[1] Such local methods are effective when problems are clearly identified.

Hyperactivity. There is some evidence that hyperactivity in children of alcoholic families may be genetic. With our limited knowledge of this area, it is believed that hyperactivity is not preventable but may be manageable. If hyperactive children learn to control their energy at earlier ages, they are less likely to be socially disruptive as they mature.

C. *Prevention of Mental Health Problems*

As we have seen, children of alcoholics are known to develop a variety of mental health disorders without a single distinctive pattern. In attempting to prevent these disorders from developing, it is important to be able to predict what *will* happen based on what is *already* happening with the family and the child.

Schools are an excellent place to identify children of alcoholics. With a caring person, with the inclusion of alcohol-specific material, or, as was learned by one counselor hired to work with adolescents with drinking problems, simply with the presence of someone who knows about alcohol problems,[2] students will avail themselves of help in some way.

Our thinking can take on new dimensions by using concepts such as "anticipatory crisis intervention," whereby an analysis is made of the manner in which a current event in the identified child's life will trigger the next crisis. This concept could work

[1] Perrine, 1979: personal communication.
[2] Knight, 1977: personal communication.

well in conjunction with adult detox and rehabilitation programs. For example, an event that is barely touched upon in the literature is the impact of sobriety upon the child. Young children may not understand why the disruptive parent is not home, and the nonalcoholic parent may be too exhausted to explain. The adolescent child of a recovering alcoholic probably will resent the parent's attempts to become perfect and make up for lost time. Such events as regulating hours and friends probably will seem more like interference than caring. This prevention approach calls for close work with the child as part of any adult treatment program.

In the school, the same concept can be used by a caring teacher or pupil-personnel staff member to ease a child through an upheaval at home. For example, if a staff member learns of a crisis in the home from the child's friends or from the nonalcoholic parent, care can be given to the child shortly after the crisis. Irritability, sleepiness, or falling-off of school work can be understood and dealt with directly. Sometimes if such signs are "let go" they lead to the development of unfortunate coping patterns that become increasingly more difficult to change. A pilot project using this approach currently is underway in Westchester County, N.Y., and other students are being counseled.[3]

Teaching coping mechanisms to children of alcoholics is another avenue open to schools and other agencies. One large school district that had rap sessions as an elective found that many of the students in rap groups began to speak about problems with alcoholic parents. The guidance staff decided as an "operative policy" to put the children of alcoholics into special rap groups without the students' knowledge. (The school's official policy forbade such grouping.) They found this grouping worked remarkably well. An unexpected side benefit was that Alateen members who had signed up for rap groups began to recruit others. Sometimes, when approaching a fellow student thought to have an alcoholic parent, they even identified themselves as Alateen members and spoke about rap sessions as an adjunct to Alateen.

The Omaha Council on Alcoholism piloted another approach and developed an actual "coping skills group for kids" headed by a trained professional outside the school. This eight-session program concentrates on building the self-esteem and adaptive skills of its participants.

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[3] Ellen Morehouse, 1979: personal communication.

While visiting Oregon in 1977, I learned of a program at a nearby college called Second Generation. This was a college credit, humanistic training sequence composed of adolescent children of alcoholics. They received training in group development skills and knowledge about alcohol and organized groups of children of alcoholics throughout the school system.

Other approaches used primarily to treat younger children have concentrated on the use of puppets or art work. These approaches could be adapted to train younger children in coping mechanisms. On a simple level, instead of learning just that they are angry, young children can learn what they should do with their anger and how not to provoke parents with their "new feelings."

Another prevention approach particularly well suited for schools and children of all ages is to encourage the participation of children of alcoholics in group and after-school activities. This participation will give the children a chance to learn social skills and have adult supervision after school.

The CASPAR program (Deutsch, 1979) focuses on training the teacher to conduct 10 sessions for grades 7 to 10 that deal with presenting "images of responsible alcohol use." Through CASPAR's alcohol-education efforts, workers identified a significant number of children of alcoholics from homes where neither parent was in treatment. The CASPAR program stresses that a parent's alcoholism is not the fault of the student, alcoholism is an illness, alcoholics can and do recover, and the child needs and should get help for him or herself.

Barriers

Barriers fall into three general categories: our lack of knowledge, our own inertia, and the general drift of primary prevention. Our own lack of knowledge is the first barrier. We must perform more carefully designed and controlled research. We must look at the changes that take place in the child after different lengths of sobriety in the parent and look at the difference in problems experienced by males and females. It would also be wise to have a longitudinal study or make these questions part of an already planned longitudinal study. In some ways, such studies may not further our "clinical" knowledge as much as they will begin to prove to others those aspects that we find "obvious." What has not been obvious is "who makes it" among children of alcoholics and why. We must research vulnerability and invulnerability and the stresses within the alcoholic home.

We must overcome our fears of stigmatizing an already stigmatized population and be prepared to be more aggressive about advocating special services.

As part of refining prevention behavioral models and images, we must begin to understand what works best in order to reach the children of alcoholics.

We must begin to refine, evaluate, and disseminate our programs so they can be used effectively.

Primary prevention, although a somewhat new field, is not immune to a call for accountability. Approaches that are "scientifically" based have been demanded. This demand has come along with questions about whether the health system is going beyond its mandate in responding to prevention [the assumption being that it should not necessarily exceed its mandate (APA Monitor, 1979)]. This will be the principal challenge to primary prevention of alcohol-related problems in children of alcoholics.

Summary

Literature about children of alcoholics and primary prevention was reviewed to delineate themes for prevention areas. The three areas that evolved were health, mental health, and alcohol-related problems. It was found that there is no one profile of the child of the alcoholic and no one prevention strategy that will cover the range of potential problems for which the child is at risk. Ideally, comprehensive programs need to be evolved; in the absence of this evolution, programs with specific objectives must adopt specific strategies. Barriers were noted, such as the need for research on "children who make it" and the need to become more accountable for our efforts to help children of alcoholics.

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APPENDIX B

Program Descriptions

County of Nassau
Department of Drug & Alcohol Addiction
Mineola, New York

Joseph C. Kern, Ph.D.

Introduction

Children have problems when they live in an alcoholic home. This has been documented in the literature and is manifested by poor school performance, acting out, or withdrawal from normal relationships. We need to correct these problems and use them as a prevention tool because these children are crying out for help that is urgently needed.

Services for children are delivered by this department through an existing alcohol outpatient unit. The unit was begun approximately 5 years ago and consists of alcoholism counselors, social workers, and part-time psychiatric evaluators. Early in our treatment history, the need for some type of children's program became evident. Spouses not only were concerned about their alcoholic mates, but also about their adolescent children. During the summer of 1977, a coordinator of children's services was hired to initiate intake and services for children of alcoholics.

Initially, a caseload was built by the coordinator working with other staff members to help them see the value of services for children of clients already in the facility. This effort consisted of both formal and informal discussions and case consultations in which techniques were developed to assist the family in bringing their children in for evaluation and treatment. Subsequently, the intake process changed in that the majority of referrals now came from groups outside the unit: probation officers, family courts, school guidance counselors, school psychologists, and direct Al-Anon and AA referrals. In addition, the other alcoholism service components in the county (rehab. unit, halfway house, and outpatient units) also have initiated referrals. This

Table 1. Data sheet—children of alcoholics, September 19, 1979

Number treated since 1977

Discharged = 56
Active = 77
Total 133

Profile[1]

Alcoholic Parent:

Mother	Father	Both Parents	Grandparents
21 (20%)	65 (63%)	15 (15%)[2]	2 (2%)

Parental marital status:

Married	Separated/Divorced
49 (48%)	54 (52%)

Religion:

Catholic	Protestant	Jewish	Other or None
76 (74%)	11 (11%)	5 (5%)	11 (10%)

Average number of siblings:

Average = 3.07
Range = 0 to 13

Average length of treatment:[3]

7.6 months

Sex:

Male	Female
52 (50%)	51 (50%)

[1] Data were available on 103 of 133 cases.
[2] However, there were in 20 cases, or 20 percent, a combination of at least two others in the family (other than parents) who were alcoholics (e.g., uncle, sibling, etc.).
[3] For 51 discharged clients on which data were available.

has resulted in the child now being the "primary client," and the parent becoming involved as a "collateral" client. This structure will be discussed more fully below.

Population Served

The program currently serves children of alcoholics between the ages of 7 and 18. It is the policy of the unit that one or both parents also must be in treatment at the same time as the child. (See table 1, Data Sheet—Children of Alcoholics, for further statistical information.)

Program Description

We currently are separating children into two age categories that seem natural groupings based on developmental criteria. In the educational component, which is the initial phase of treatment, children are grouped by ages 9 to 12 and 13 to 18. In this entry-level phase, separate therapists conduct educationally oriented groups for these children. The children later are entered into therapy groups where there is some age mixing based on desire for treatment and appropriateness for a group.

Education Series

The outpatient unit has had a longstanding education program for spouses of alcoholics held on Wednesday evenings. It seemed appropriate that the educational services for their children should be conducted at the same time and place in order to overcome the resistance concerning transportation. Hence, an education series is conducted from 7 to 8:30 p.m. for the children in both age categories simultaneously, with a program for their parents held in the same building.

The goals of the education series are to:

- Provide education about alcoholism (to view it as a family disease)
- Develop in the clients a healthier personal outlook (to enable them to recognize and deal appropriately with their feelings, especially guilt)
- Help provide them with alternative ways of responding to life in an alcoholic home
- Build self-esteem and increase self-awareness
- Build a sense of trust of adults through the counselor who is a consistent figure and can aid as a role model
- Involve and treat the family as a whole
- Strive to prevent further disorders—an ongoing component of all treatment modalities because we recognize this population as one at high risk

A. *Education Series for 9- to 12-Year-Olds*

The format, which has been selected by the children themselves, is one of an informal "rap." The younger children relate well to an unstructured format in which items of current interest (sports, school, etc.) are encouraged to be the initial points of discussion, which, in turn, can blend into a discussion of alcoholism and the family. A structured classroom format is carefully

avoided in order to provide the sense of freedom to express and share. In terms of commitment to the program, members are asked to make a contract for a minimum of 10 weeks' involvement. The therapist has material and topics planned for each week but carefully integrates this material based on current interest and topics of discussion presented by the children.

Initially, after the 10-week introductory phase, we planned to move these children into ongoing closed groups. Retention in the series is based on a weekly case conference in which each youngster is assessed for need in continuing involvement in the education series or movement into individual counseling or group therapy. Hence, not every child requires long-term care; each case must be assessed on an individual basis. On the average, there are 18 children in the group each week. Due to staff limitations we have not been able to open up as many advanced groups as could be filled. Therefore, some of these youngsters have been held in the entry-level education component for several months.

B. *Education Series for 13- to 18-Year-Olds*

The older age grouping (13 to 18) employs a more structured format in which the group leader uses growth potential exercises to stimulate discussion and sharing. Although there are fewer participants in this age category, probably because of the natural resistance of adolescents, they are moved more systematically into ongoing groups after the initial 10-week introductory phase.

Group and Individual Therapy

A. *Group Therapy*

Group therapy is the treatment of choice for these children. Current groups, beyond the education series, consist of:

- Monday night group, ages 10 to 14, both boys and girls, 7 to 8 p.m. There are approximately eight youngsters in this group, and the average length of treatment has been approximately 1 year.
- Thursday afternoon group, 4:30 to 5:30 p.m., ages 12 to 15, female only. This group has evolved into a female-only group, which has proved beneficial in overcoming resistance to sharing in front of boys at this age and fulfilling the need for a consistent female role model in the form of the group therapist. There are approximately seven members in this group, and average length of treatment is 1 year.
- Monday night group, 8:15 to 9:45 p.m., ages 16 to 18. Average

length of treatment is approximately 1 year. Group is male/female.

All these groups are conducted on an informal "rap" basis and deal with issues presented by group members.

B. *Individual Counseling*

Of the active caseload of 47 children, approximately 40 percent are being seen in individual counseling. Selection is based on need as follows: (1) Children living in an active alcoholism home generally are judged to require individual counseling in addition to the education group. (2) The younger children in the age category of 7 to 9, for which there is no group currently in existence, are seen individually. (3) Some children are deemed inappropriate for group therapy and unready to begin the socialization process involved in a group, and hence are seen individually. A goal for these children is to help them grow to the point where they are ready for a group experience.

Summary

The services offered consist of two entry-level education series, four ongoing group-therapy sessions, and approximately 20 individual counseling sessions per week.

As will be described below, the above services have acted as a case-finding mechanism for children with alcohol-related problems.

A. *Assessment of Program Experience: Problem Areas*

Length of Treatment. Initially, it was believed by administrators that brief therapy would be adequate for these children. Despite the apparent lack of movement in the group over a 10-week period, a 3-year followup of the involved families indicated that almost all the children initially seen in this brief therapy workshop were later in treatment for alcohol, drug abuse, or other problems. We learned from this experience, however, that length of treatment must be individualized. Some children are seen for brief crisis intervention episodes, while others are seen for upwards of a year to 18 months.

Family Involvement. It is the current policy of the unit that one or both parents must be in treatment simultaneously with the child. For example, the Monday night therapy group for children has a parallel component—a "parenting" therapy group conducted by another therapist at the same time the children are in

treatment. This group is composed of spouses of alcoholics who have had considerable treatment experience but require skills in learning how to parent their children and react to their growth. Most of the current group's families are broken—they are single-parent households—and this factor provides additional topics for discussion.

Parents of other children currently in treatment are required to be in some phase of therapy, which can range from individual counseling and spouses groups to participation in the parents' education series. Our experience has been that unless one or both parents are actively involved, they will withdraw the child from treatment as the child becomes more verbal and assertive of his or her needs. Since the younger children need help with transportation, it is important to gain the parent's cooperation in bringing the child to treatment and then for the parent to see the therapist as an ally rather than as a competitor for the child's loyalties.

Separate Groups. Our original conception was to involve the sober parent and child in treatment together from the initial contact with the agency. Our experience, however, has indicated that these children were not ready to share their feelings in front of either parent. Hence, separate groups have been established for them.

On an as-needed basis, some families are seen together for purposes of crisis intervention and confrontation or for the resolution of ongoing problems. However, these sessions are carefully planned, and individuals are screened for their appropriateness and strength to deal directly with the resulting family confrontation.

Staff Consultation. It is imperative that the administration fully support the development of these programs in order to overcome resistance from more tenured staff. Services for children of alcoholics are largely lacking in existing treatment networks, and the introduction of staff to treat them may be seen as a criticism of current efforts and reacted to with passive hostility. Specifically, alcoholism counselors and family counselors have a natural vested interest in their adult clients and realize that the attainment of sobriety is of paramount importance and must precede growth of the rest of the family. Hence, a supervisor needs to understand adolescence, family systems theory, and the dynamics of staff interaction in order to successfully introduce these services into an agency.

Staff. It is an error to assume that existing staff automatically can absorb a caseload of children into their current caseload. Mandating such services through existing staff is likely to meet with failure. Instead, we have found it is necessary to hire specialized staff who are dedicated to seeing children as the "primary clients" and acting as their advocates. The staff person should be completely knowledgeable about alcohol and alcoholism and possess a unique knowledge of children and the adolescent process.

Lack of Staff. To our surprise, this program component has grown rapidly and has had a domino effect on other services. For example, some of these children have been identified as alcohol abusers, which requires other agency staff to begin new alcohol adolescent groups for these children. These groups are in addition to the "parenting" group described above. Also, these services open up new relationships with the family court and criminal justice system because some of these families are court involved. This requires additional staff skills and time to provide liaison with the criminal justice system and to learn how to advocate for children's rights. This development also has brought us into the area of abused families and women, in terms of training seminars and liaison with that sector of the helping professions.

The attached statistical fact sheet summarizes our experiences over the past 2 years. There are currently 77 children of alcoholics in treatment ranging from entry-level education series through advanced therapy groups. Additionally, another 56 have been treated and have left the agency.

Impact on the Alcoholic. The children are seen and treated as "primary clients." Their needs are considered paramount, which is to say they are not treated as a "collateral" nor as if their treatment status were dependent on the sobriety of the alcoholic or the behavior of the sober parent. However, we have found that the child's progress can have a beneficial side effect on the drinking alcoholic. In at least 50 percent of our caseloads, the child's continued growth in treatment has motivated the alcoholic to seek help. This process occurs over many months, but many of the alcoholic parents eventually find their way into treatment, in part, because of the crisis provoked by the child's growth. This has been particularly evident with the female alcoholic whose children are in treatment. Her role of mother and parent and her desire to be a "good mother" is often the initial hook for the beginning of treatment.

Research. Much more needs to be known about these children and the best ways to help them. Currently, we are conducting two studies:

- Followup. We have followed up on members of a brief therapy group we conducted several years ago. Most of the participants (children) developed drug, alcohol, or other problems and entered treatment some years later.
- Locus of Control/Zinc Levels. We currently are conducting a study of 20 children of alcoholics matched with 20 controls. Preliminary data indicate that the children of alcoholics have depressed zinc levels and are externally oriented in terms of reinforcement. A more complete description of the study will be available later this fall, but once again results indicate that children of alcoholics have multiple problems.

In summary, our experience confirms that the children of alcoholics are a high-risk group for the development of alcohol, drug, substance abuse, and related disorders. We recommend that NIAAA launch a strong campaign through the existing grantees to mount programs for these children in order to prevent a new generation of alcoholics from developing.

The Children of Alcoholics: Program Needs and Implications Derived From Experience Within the Adolescent Alcohol Abuse Treatment Program—The Door, New York City, a Multiservice Center for Youth

Susan Landes, M.S.

Introduction

The adolescent alcohol abuse treatment program (AAATP) is a comprehensive treatment and rehabilitation program for young people between the ages of 12 and 21 who are at risk because of parental alcohol abuse and/or who are themselves abusing alcohol. It is an ambulatory, community-based program located in the Village/Chelsea area of Manhattan, serving adolescents from throughout New York City, with an emphasis on disadvantaged, inner-city youth. The program is funded by NIAAA and is in its second year of operation.

AAATP is a part of The Door—A Multiservice Center for Youth. The Door is an integrated human service system organized around holistic services and activities designed to meet a wide variety of needs of young people. Clients have available, as an integral part of their program, psychiatric services, comprehensive medical services, family planning and sex counseling services, nutrition counseling, a food services program, social services (housing, public assistance, food, etc.), education counseling, a learning center program (including remediation of and tutoring in basic skills, high school equivalency, and English as a second language), vocational counseling, career education and training, legal counseling, vocational training workshops, recreational activities, and creative workshops and experiences.

Nature of the Problem

AAATP utilizes a total person approach, focusing on the underlying causes and the related physical, emotional, intellectual, interpersonal, familial, legal, educational, vocational, and life problems and needs of children of alcoholics and of youthful alcohol abusers. Young people who are at risk because of parental alcohol abuse, as well as those young people for whom alcohol is becoming a means of coping with the problems, crises, and changes of adolescence, are identified and encouraged to become involved. By helping these young people understand their problems and by finding constructive solutions to them, it is possible to avert more serious, prolonged impairment of personal development and its related impact on their lives and the lives of others.

Adolescence is a time of rapid change requiring the resolution of basic developmental issues in regard to identity formation, emergent sexuality, societal roles, independence, and authority. A constantly changing view of the self and others evokes anxiety and confusion because there is movement toward becoming an independent human being. Adolescence is also a time when the pressures to acquire the skills necessary to function successfully as an adult intensify. For those young people who because of difficult early childhood experiences reach adolescence with little security or trust in their own ability to deal successfully with life, these anxieties and demands can become overwhelming. The results may be passivity, inactivity, and flights into fantasy that greatly retard the resolution of the adolescent tasks necessary for the development of a mature, creative, and responsible adult.

This paper will highlight program needs, goals, and consequences for children of alcoholics, relative to the adolescent reality. Reference will also be made to adolescent alcohol abuse. Similar characteristics, behavior patterns, and psychodynamic factors have been found in both populations at The Door, necessitating comparable program structures and goals. In addition, clinical experience at The Door, as well as the experience of many clinical researchers, indicates that over 50 percent of adolescent problem drinkers come from families with a history of alcoholism or other substance abuse and learn destructive and irresponsible drinking patterns from parent models. Thus, the children of alcoholic parents constitute a particularly high-risk group for alcohol abuse and other negative behavior.

Problems for these adolescents center on difficulties in meeting important personal and interpersonal needs as well as achieving independent functioning. A sense of emotional frustration and

hopelessness, precipitated by anger, passivity, and dependence, impedes the development of a positive identity and its accompanying sense of human value. Because children of alcoholics have been deprived of their parents' emotional support and because many family concerns usually take the form of denying, supporting, and camouflaging the alcoholic's drinking and resulting behavior, there is a general absence of responsible parenting. Controlling dependent behavior takes the place of genuine responses and limits structuring of integrated personal and educational/vocational goals. There is a general denial of feelings and of emotional needs, with an expectation that children will meet their own needs independently, and at the same time be overly sensitive to the needs of the parents. Feelings of worthlessness, confusion, anger, and abandonment precipitate acting out behavior in response to the stresses of growing up. This negative, destructive behavior surfaces at school, with peers, at home, etc. Denial is the primary defense learned within the alcoholic family system.

Margaret Cork, head of the Addiction Research Foundation's Youth Counseling Services in Toronto, Canada, has stated that *90 percent of the children of alcoholic parents suffer serious emotional and physical damage.* Among the consequences are physical or psychosomatic illnesses such as asthma or ulcers; inability to concentrate in school; poor relationships within and outside the family; fears about being unliked or different; lack of confidence with the opposite sex; anxiety about the future; too much responsibility early in life; feelings of being upset, rejected, easily ashamed; lack of self-confidence generally; constant anger and hostility; inability to trust others; constant defiance of authority; feelings of hopelessness, depression, lack of ambition; passive life attitudes; constant thoughts of escaping from responsibilities; and feelings that family life is not worthwhile. The fact that almost all children of alcoholics suffer emotional disturbances is an indication that if any of them turn to alcohol to meet their emotional needs, there is a great possibility that they will, themselves, become alcoholics. In families where alcohol is misused by parents and where the parents are ambivalent and guilty about their own drinking habits, confused messages about drinking are often transmitted to the children.

In summary, many adolescent children of alcoholics are isolated, alienated, depressed, and have difficulty expressing themselves interpersonally and functioning in a productive and creative way. As they separate from their families they look to their

peers for support, direction, and confirmation of their identity. Instead, they frequently experience competition, lack of support, and exploitation. They fall into destructive patterns of relating, often abusing alcohol and engaging in self-destructive behavior in their quest for acceptance and peer approval. Increases in truancy, violence, unemployment, welfare, runaway youth, delinquency, teenage pregnancies, prostitution, accidents, and suicides are but some of the more obvious social, health, and mental health problems that surface within this population during the adolescent years.

Population Served

Since November 1978 (the start of the second year), the alcohol treatment team, together with other appropriate Door staff, have identified and provided services to 377 young people who used alcohol to any extent or who were considered at risk because of parental use of alcohol. Of the 377 young people, 302 were reviewed for admission to AAATP by the full alcohol treatment team in their formal intake review sessions; the alcohol involvement or family history of the remaining 75 was not sufficient to warrant review by the team. (See table 1.) Demographic characteristics of clients and the extent of their use of alcohol are further detailed in tables 2 and 3.

Program Overview

Treatment strategies for AAATP focused this year on structuring and developing intensive program parameters incorporating short- and long-range treatment goals and modalities and on determining how to effectively sustain a young person's involvement in the program and, more generally, at The Door. Program-specific, age-related therapy groups and education/rap seminars presented by interdisciplinary team members and short-term, goal-oriented vocationally related introductory creative workshops were implemented to meet the needs of program participants.

A. *Purpose*

The purpose of AAATP is to identify, to be a resource, and to provide holistic, integrated treatment services through an interdisciplinary team to children of alcoholics and youthful alcohol abusers.

Table 1. Numbers of young people screened for admission to AAATP, Nov. 1978–May 1979

Category of Young Person	Number of Young People	Percentage of Total
Total candidates screened by the alcohol treatment team	302	100
Accepted for AAATP	61	20
alcohol user	27	9
no use/parental use	34	11
Reviewed but deemed not appropriate for AAATP[1]	241	80
Number of young people active in AAATP, Nov. 1978–May 1979		
Active on Nov. 1, 1978	52	
Admitted to program Nov. 1978–May 1979	61	
Total	113	
Active as of May 31, 1979	68	

[1] Although 241 young people were deemed not admissible to AAATP at the time of their review (primarily because of the nature or extent of their alcohol involvement or that of their families), all were, in fact, reviewed by the team, referred to, and provided with services related to the specific life issues that brought them to The Door.

B. *Goals*

The primary goals of the program are:

To intervene in the personal and social development of identified youth by replacing negative, destructive behavior with emotionally satisfying, interpersonal, functional, and creative experiences and by resolving the problems therein.

To encourage, support, and assist toward overall responsible functioning, maximizing strengths, capabilities, capacities, and the positive growth and development of individual identity and independence.

Short-Term Goals (1 to 3 Months)

To motivate and to make a commitment to work toward recognizing and identifying problems, needs, and goals. Major focus on developing insight, establishing a meaningful counselor/client relationship, and establishing a consistent, caring peer-support system.

An educational program provides an understanding of alcohol use versus abuse and its impact in all life areas. Medical evaluation insures quality/comprehensive health care. When indi-

Table 2. Demographic characteristics of young people active in AAATP, Nov. 1978–May 1979

	Number of Young People	Percentage of Total
Sex	Risk/Use	
Female[1]	60 (36/24)	53
Male	53 (17/36)	47
Total	113 (53/60)	100
Ethnicity[2]		
White	31	27
Black	43	38
Hispanic	36	32
Other[3]	3	3
Total	113	100
Age		
12–15	3	3
16–17	27	25
18–19	42	36
20–21	31	27
> 21	10	9
Total	113	100

[1] AAATP has been especially successful in reaching and involving large numbers of young alcohol-involved females, a population whose treatment needs are just being recognized and who have traditionally been underserved.

[2] AAATP has been successful in reaching and involving a broad cross section of New York City's adolescent alcohol-involved population, as demonstrated by the heterogeneous ethnic composition of its clients.

[3] Mainly Oriental.

cated as positive, focused short-term/goal-oriented workshop involvement aims toward meaningful use of time, self-actualization, and eventual ongoing Door involvement.

Modalities. Individual and intensive age-related group therapy, medical evaluation and followup, multidimensional alcohol abuse education/rap seminars led by interdisciplinary team members, and introductory services/workshops.

Long-Term Goals (3 to 12 Months) To sustain and stabilize process of change and identify development, socialization, and meeting goals. Continued personal, social, education/vocation, creative and recreational needs, development, and involvement. Involvement in

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Table 3. Extent of alcohol use among young people active in AAATP, Nov. 1978–May 1979 [1]

Extent	Number of Young People	Percentage of Total
Once/Week	20	18
2–3×/Week	13	11
More than 3×/Week	6	6
Daily	21	18
No Use/Parental Use	53	47
Total	113	100

[1] It should be noted that 35 percent of the young people active in the program were using alcohol from 2 to 3 times per week to daily, and 53 percent were from families where there was an alcohol problem.

AAATP is maintained through group therapy with simultaneous utilization of regular and ongoing services, workshops, and activities of The Door.

Modalities. Group therapy and ongoing Door services and workshops.

Interdisciplinary Adolescent Alcohol Abuse Treatment Team

The core group of staff for the alcohol treatment team consists of people hired under the NIAAA grant: a project director, three alcohol counselor therapists, an education/vocation counselor, a physician, a nurse, and a psychiatric/administrative liaison statistical representative. In order to broaden the disciplines represented, a nutritionist, a workshop instructor, and a social worker have been added. This team is responsible for providing services to alcohol-abusing and high-risk youth based on the aforementioned program that incorporates short-range and long-range goals and modalities. The team also functions as the central resource group for staff education and training, referrals, and other matters related to alcohol-abusing youth. Team meetings chaired by the project director are held each week, at which time all new intakes are assessed for their appropriateness for inclusion in the program. Treatment planning, ongoing case management, and treatment review are other important functions of the team.

Each team member functions as the representative of a particular discipline and service and as the service resource person for young people in the program. Each takes responsibility for followup of those young people receiving his or her services who abuse alcohol but are not involved in an intensive alcohol treatment program. Each team member's main function in this case is to contact the main service provider to ensure that the client's alcohol abuse either is being addressed or will be at the appropriate time.

The alcoholism counselors are the focal therapists providing ongoing individual and group counseling and ensuring appropriate involvement in the program and progress toward relevant, consistent goals. The nurse and physician on the team are responsible for medical examinations and for ongoing health care for program participants, with special focus on alcohol-related complications and their impact over time. Because of their importance to an adolescent, family planning and sex counseling are available whenever appropriate. A nutritionist deals with nutritional concerns and problems. A social worker is available for young people who have run away from home or have been "thrown out" and have critical need for assistance with temporary or long-term residence, food, clothes, money, and temporary work. An education/vocation counselor is available to deal with the education, training, and work needs of young people in the program. The creative workshops representative serves as the resource person for the creative, vocational training and recreation/sports workshops and activities. A statistical clerk is responsible for internal and National Alcoholism Program Information System recording, tracking, and statistical mechanisms.

Identification and Intervention—Alcohol-Abusing and High-Risk Youth

Screening, intake review, and followup procedures were implemented to establish clear, effective intervention strategies and mechanisms. Because of the large volume of young people who use The Door each month (over 2,000 different individuals), effective inreach and staff training continue to be a high program priority. As was expected, many adolescents denied or underestimated the significance of parental alcohol abuse on their lives and, as a result, continued first to seek help with other life problems that they felt were more important. A staff education and training program on children of alcoholics and adolescent

alcohol abusers helped staff (who made initial contact with these young people) to recognize the significance of parental alcohol use, to be able to talk to the young people about it, and to make appropriate referrals.

The multidimensional nature of The Door has required formulation of a mechanism whereby all newly opened charts from all services are screened and reviewed by the alcohol treatment team. All new Door clients are routinely given a thorough initial interview in the service first contacted. The interview includes questions about history and pattern of alcohol and drug use; education; vocational and socioeconomic status; family history; peer relationships; and medical, psychiatric, and legal history as well as more specific information related to the major problems identified by the young person. Each initial interview becomes part of a centralized chart that is reviewed and presented to the team which, in turn, determines appropriateness for admission.

The specific questions concerning substance use, amounts, times used, and attitudes incorporated into the initial interview form are particularly useful in judging the interrelationship between quality and extent of alcohol abuse. If young people drink in response to emotional stress, loneliness, or to escape life's realities, and if they experience problems in any major life area, they are appropriate for admission. Young people who have been exposed to parental alcohol abuse with resulting emotional instability and problems in any major life area are also appropriate for admission.

An intake review format highlighting essential information for determining appropriateness for admission to AAATP was developed for use by all alcohol team members this year (appended). A service-related team member reviews any chart indicating more than occasional alcohol use and presents the chart to the team, using the format as a guide. Demographic information, young person's or family alcohol use/abuse, psychosocial functioning, medical and legal status, education/vocation status, special interests, and relationships with family and friends are all assessed. Then an evaluation is made of the young person's strengths and problems, and a decision is reached regarding admission to the program. A followup on all admissions is required within 2 weeks of admission at which time an initial treatment plan review takes place. All reviews and dispositions are recorded by the statistical representative as are dates for initial treatment plan reviews.

Development of Appropriate Treatment Strategies

Those young people who have a family member with a significant alcohol abuse problem or who have an alcohol abuse problem themselves and are exhibiting serious dysfunctions in their ability to cope with their life tasks are placed in separate, specialized therapeutic groups and introductory workshops. In addition, parents are involved via family counseling or through appropriate community agencies such as Alcoholics Anonymous, Al-Anon, family counseling centers, and other human service agencies. All clients have a member of the alcohol treatment team as their primary counselor and participate in the education/rap discussion groups as well as in special projects specifically oriented to these populations.

A. *Short- and Long-Range Treatment Goals*

Short- and long-range goals were made more responsive to the specific needs of alcohol-abusing and high-risk youth. Modalities and activities were defined as means to achieving these goals on the basis of each young person's needs and level of functioning at various stages of treatment. This refinement and structuring has been a necessary and useful response to the disorganized, fragmented functioning and lifestyle of alcohol-abusing youth who typically remain uninvolved in meaningful relationships and activities.

B. *Initial Treatment Goals and Strategies*

The initial focus of the program is to initiate and develop the emotional interpersonal relatedness and incipient sense of well-being required for involvement within The Door milieu and the therapeutic program. This is accomplished by motivating the adolescent to work toward decreasing alcohol use and toward more meaningful change and self-actualization. Important components in this initial process are: establishing a positive, caring, therapeutic relationship with a counselor; providing an understanding of the impact of alcohol use/abuse on overall functioning and specific life areas; developing a caring peer and staff support system; providing meaningful, productive opportunities for positive use of time activities and workshops; providing active followup and assuring the young person of the sincerity of the counselor's interest and concern; and stimulating more insights through evaluation and feedback on the client's level of involvement in the program as related to his or her level of alcohol use, psychosocial functioning, and functioning in life

areas. Following are the descriptions of some of the specific treatment components developed in the past year in response to the treatment strategies outlined above:

Intensive Age-Related Group Therapy. Crucial to the success of the program has been the creation of a meaningful, satisfying peer and staff support system to combat the perpetual sense of alienation and isolation that leads to negative, acting-out, destructive behavior. Toward this end, therapy groups organized by age meet twice each week, making it possible to deal more effectively with similar school, peer, and social concerns that are presented at different stages of development. Psychodynamics, interpersonal functioning, and group process are explored on an ongoing basis. The groups, each with 8 to 10 members, have met regularly with good attendance. Group members have relied on the meetings for emotional support and interpersonal relatedness and have talked freely about their family experience with alcohol abuse. Separate groups for children of alcoholics respond to the needs of these young people in order to identify and cope with the effects of parental alcohol abuse on their lives.

Medical Evaluation and Followup. Medical evaluation and followup has been an important requirement for all program participants in the short-range intensive program. Most alcohol-abusing youth experience some physical discomfort as a result of excessive drinking, while a few have already developed more serious gastrointestinal complications. During the medical evaluation, the team physician and nurse discuss the physical implications of alcohol abuse with the young person and provide the necessary treatment. Nutritional needs are addressed at this time and remain an important area of focus.

Education Seminars. The interdisciplinary alcohol treatment team has developed and is presenting ongoing client education seminars, movies, role plays, questionnaires, and discussions relating to various aspects of alcohol use/abuse from historical, psychological, social, medical, nutritional, pharmacological, environmental, and educational/vocational perspectives. Participation in the seminars is expected of all program participants as well as general Door members, thus addressing the alcohol abuse prevention needs within The Door community. Because alcohol use is woven into the fabric of our society, factual information can help young people clarify their own alcohol use and its related implications. These seminars, led by alcohol treatment

team members, will be taken to schools, community groups, and outside agencies to expand The Door's outreach component.

It has been mentioned that alcohol-abusing, at-risk adolescents experience confusion and anxiety about their own identity, have difficulty understanding their past and present reality and potential, and need help identifying major areas of concern. Blame and self-deprecation are strong in the psychological systems of these youth, in part because of ignorance about motivating factors that lead to alcohol abuse and its resulting problems. With clear, factual information provided by the education seminars, program participants are more able to combat and openly discuss their deep-seated conflicts with other young people.

A substance use information and education center has been developed as a component of The Door's health advocacy program, a program that addresses health and mental health issues through preventive techniques—education, literature, rap groups, and films. Graduate students and trained youth workers staff the center, which has available pamphlets, handouts, and other information. The education seminars, led by alcohol treatment team members, will be a part of the center's regularly scheduled activities during the coming year.

Short-Term Goal-Oriented Creative and Educational Vocational Workshops. Special creative, vocationally oriented workshops for AAATP clients have been developed to address specific needs of the alcohol-abusing adolescent. These workshops provide the opportunity to gain self-esteem and followthrough via the specialized services, activities, and resources of The Door.

Alcohol-abusing young people exhibit poor self-control, have difficulty focusing goals, and cannot sustain the type of meaningful, productive, satisfying activities that would result in positive self-expression. Lacking a sense of self-worth, these young people typically avoid social and task-related experiences, as well as the growth and pleasure involved in positive activities, preferring to withdraw to create their own reality, often with the help of alcohol. The workshops, which meet twice a week for a 6-week period, were developed to offer a structured alternative to this type of behavior, giving the young people a positive sense of their own productive capacity within a social, functional context. Introductory, vocationally oriented, creative workshops in the woodworking and jewelry-making areas have focused on helping the young people create quality products while learning new techniques, skills, and knowledge. Introductory education and vocation groups have been formed, geared toward introduc-

ing the alcohol-abusing young person to the learning center and serving whatever individualized needs related to school and work that he or she may have. Recreational activities have been organized to encourage team and individual sports. Staff offering these workshops receive special training and meet regularly with the project director and alcohol treatment team staff to determine treatment strategies and assess individual progress. All workshops have been successful with a sample group of clients. Future workshops will involve greater numbers.

C. *Long-Term Goals and Treatment Strategies*

Long-term goals are to sustain, stabilize, and continue improved functioning in personal, social, interpersonal, health, school, work, and recreational life areas through involvement with relevant services and activities of The Door.

After a solid therapeutic alliance has been established with the client and a commitment to consistent involvement with the program has been made, the counseling shifts to an intensive group experience and away from individual therapy. The client becomes involved in the regular ongoing services of The Door and makes a commitment to one or several creative/recreation workshops or activities. The primary counselor continues to work with the young person on a regular basis to offer support and assess progress.

Quality and Comprehensive Care Mechanisms

Alcohol treatment team staff have participated regularly with other staff from The Door in four ongoing task forces: program, client flow, quality of care, and records. These task forces seek to improve the effectiveness and quality of care being provided to young people, to develop a more effective monitoring system of client involvement in the program, and to improve the documentation and recording of services provided by The Door programs. The participation of alcohol treatment team staff has been important in bringing to these meetings an awareness of the needs of alcohol-abusing youth as well as in satisfying the NIAAA reporting obligations.

A. *Initial and Quarterly Treatment Plan Reviews and Formats*

Initial and quarterly treatment plan reviews are an integral part of the weekly alcohol treatment team meetings this year. The primary counselor or team member assigned to a young

person is responsible for preparing and presenting the review(s) using predefined formats. Degree of involvement, progress, and treatment goals are reviewed, ensuring optimum utilization of team resources, maximum staff input in formulating treatment plans and goals, consistency of approach, and appropriate followup.

Initial Treatment Plan Review. The initial treatment plan review (appended) is presented shortly after a young person's admission to the program, and assesses the young person's functioning, problems, needs, and strengths. The areas reviewed are: young person's or family's alcohol use/abuse, psychosocial functioning, health status, vocation/education status, and creative/recreation functioning. Subsequent treatment planning then focuses on individualized short- and long-range goals, plans, and modalities with projected time schedules for goal achievement incorporating additional team input.

Prior to the reviews, the young persons are contacted in order more fully to explore the nature of their or their family's alcohol involvement; where appropriate, counseling is encouraged. If the young person is willing to become involved in counseling, a counselor is assigned at that point; when this is not possible, the service-related team member remains the primary counselor, overseeing the young person's program involvement, following up to insure continued concern and contact around alcohol use, and insuring that a referral to counseling is made at the appropriate time.

Quarterly Treatment Plan Review. The quarterly treatment plan review (appended) assesses the progress made by the young person and the effectiveness of treatment goals and plans and defines future goals and plans. One week prior to the review date, the statistical representative informs the primary counselor of the upcoming review, allowing time for adequate counselor review and preparation.

Staff Education and Training Program

Staff education and training workshops for all Door interdisciplinary staff have been developed by drawing upon the resources of team members. Material is presented by team members in weekly seminars over a period of a few months in the form of group presentations, role plays, discussions, movies, tapes, and plays to convey the multidimensional nature of alcohol abuse—its causes, implications, and treatment strategies. The

seminar schedule includes: introductory material related to incidence, prevalence, and current trends in adolescent alcohol use/abuse; funding agency requirements; sociocultural factors, dynamics, and patterns; individual and environmental alcohol use/abuse dynamics, patterns, and lifestyles; alcohol use/abuse in adolescence—patterns of family interaction and value systems; physiological effects of substance use/abuse; pharmacology; The Door's adolescent alcohol abuse treatment program as compared with other approaches; and combined alcohol and drug use.

The staff training has been effective in sensitizing them to issues related to alcohol use, in increasing staff awareness of alcohol use among the adolescents who utilize the services and programs of The Door, and in stimulating referrals and effective intervention. A program schedule for the training series is appended.

Assessment of Program Experience

A. *Areas of Unusual Success*

1. Identification. Initial interview format very effective in eliciting accurate responses in conjunction with staff training
2. Staff training and referral. Essential, ongoing, using schedule
3. Initial and quarterly treatment plan review forms. Insuring planning and work in relevant areas
4. Treatment of both individual and group

B. *Areas in Need of Improvement*

1. Staff morale. Difficult clients to work with
2. Sustaining involvement in treatment. Have to continue to provide incentives
3. Family involvement. Drinking parent usually won't cooperate, forces continued anger
4. Finding appropriate placement, especially residential

Adolescent Alcohol Abuse Treatment Program: Intake Review Format

Initial Interview Date: _____ Service: _____
Interviewer: _____ Program Staff Reviewing: _____

Identifying Information
Name: _____ Age: _____ Ethnicity: _____
Address & Living Arrangement: _____
_____
School/Work: _____
Reason Came to The Door: _____ Special Interests: _____

Substance Use

	Preferred Type	*How Often*	*When*	*How Much*
Alcohol:				
Other:				

Family Member/Significant Other has had problems with alcohol: ____
_____
(a) Has lived with person over time? _____
(b) Has been intimate, closely involved with person? _____
(c) Was/is dependent on for support, shelter, etc.? _____
Sees any of above as a problem? _____ Wants help? _____

Health/Mental Health

Psychosocial Functioning
Psychological Functioning re sense of self: setting, structuring and following through on goals: _____
Interpersonal Functioning:
—Family Relationships/Parents: _____
/Siblings: _____
—Peer Relationships: _____
—Relationships with Adults/Authority Figures (teachers, bosses, etc.): _____
—Sexual Behavior: _____
Previous Psychiatric Treatment: _____
Medical Status
Medical Problems/Ailments: _____
Medications: _____
Difficulty Sleeping, Eating, with Way Body Looks: _____

Legal Problems/Questions

Formulation
Problems:
Strengths:
Disposition re Alcohol Abuse Program:

Adolescent Alcohol Abuse Treatment Program: Initial Treatment Plan Review

Client Name _____ Program Admission Date ____
Counselor _____ Review Date _____

Problem Areas

1. Alcohol Abuse (or Family History of) _____
   _____
2. Psychosocial Functioning _____
   _____
3. Medical _____
   Nutrition _____
   Sex & F.P. _____
4. Education _____
   Vocation _____
5. Creative Functioning _____
   Recreation Needs _____

Short-Range Goals and Plans (1-3 months)

1. Indiv. Counseling: GOAL _____
   PLAN _____
2. Group Therapy: GOAL _____
   PLAN _____
3. Medical: GOAL _____
   PLAN _____
   Nutrition: GOAL _____
   PLAN _____
   Sex & F.P.: GOAL _____
   PLAN _____
4. Alc. Ed. Seminars: GOAL _____
   PLAN _____
5. Short-Term Goal-Oriented Workshops: GOAL _____
   PLAN _____

Long-Range Goals (3-12 months)

1. Group Therapy: GOAL _____
2. Ed./Learning Ctr.: GOAL _____
3. Vocation: GOAL _____
4. Creative Wksp. (Ongoing, Reg. Wksp. of Choice): GOAL _____

Team Member Presenting: _____

Adolescent Alcohol Abuse Treatment Program: Quarterly Treatment Plan Review

Client Name _____ Program Admission Date ____
Counselor _____ Review Date _____

Problem Areas

1. Alcohol Abuse (or Family History of) _____
2. Psychosocial Functioning _____
3. Medical _____
   Nutrition _____
   Sex & F.P. _____
4. Education _____
   Vocation _____
5. Creative Functioning _____
   Recreation Needs _____

Short-Range Goals, Plans and Progress (1-3 months)

1. Indiv. Counseling: GOAL _____
   PLAN _____
   PROGRESS _____
2. Group Therapy: GOAL _____
   PLAN _____
   PROGRESS _____
3. Medical: GOAL _____
   PLAN _____
   PROGRESS _____
   Nutrition: GOAL _____
   PLAN _____
   PROGRESS _____
   Sex & F.P.: GOAL _____
   PLAN _____
   PROGRESS _____
4. Alc. Ed. Seminars: GOAL _____
   PLAN _____
   PROGRESS _____
5. Short-Term Goal-Oriented Workshops: GOAL _____
   PLAN _____
   PROGRESS _____

Long-Range Goals and Plans (3-12 months)

1. Group Therapy: GOAL _____
   PLAN _____
2. Ed./Learning Ctr.: GOAL _____
   PLAN _____
3. Vocation: GOAL _____
   PLAN _____
4. Creative Wksp. (Ongoing, Reg. Wksp. of Choice): GOAL _____
   PLAN _____

Team Member Presenting: _____

The Door—A Center of Alternatives
Staff Education and Training Series on Substance Abuse

Goals

- To explore the nature of substance use and abuse in the adolescent population
- To develop a general understanding of The Door's treatment approach as compared with other approaches and modalities
- To build an integrated, relevant approach towards the identification, referral, and treatment of adolescent drug/alcohol abusers at The Door

Seminar Schedule

Seminars will be led by members of the alcoholism team and drug abuse staff. Films, videotape, role playing, readings, and discussions will be used throughout.

Seminar I. Introduction to the Substance Abuse Program at The Door

• Program Overview	Definition of Substance Abuse Levels of Substance Involvement Incidence, Prevalence, and Current Trends: Demographic A Comprehensive Response to the Problem To Meet the Multiple Problems and Needs of the Adolescent
• Funding Requirements	NIAAA and NIDA—Federal Regulatory Agency Review and Comment
• Staff Introduction	Brief Background Statement and Comment on the Meaning of Working in a Community of Young People With Drug and Alcohol Problems

Seminar II. Substance Use and Abuse in Adolescence—Sociocultural Factors, Dynamics, and Patterns

- Substance Use and Abuse in Our Society—Attitudes, Customs, Norms, Relative to the Adolescent Reality (Alcohol, Drugs)

- Issues Relating to Specific Groups (Ethnic, Women)

Seminar III. Substance Use and Abuse in Adolescence—Individual and Environmental Dynamics, Patterns, and Lifestyles

- Consequences
  —Legal, Social, Educational, Vocational, Housing Implications
  —Use, Abuse, Addiction

  Motivations
  —An Interplay of Social, Environmental, Cultural, Psychological, and Developmental Factors

Seminar IV. Substance Use and Abuse in Adolescence—Patterns of Family Interaction and Value Systems

- The Family's Impact in Terms of Learned Behavior Patterns and the Perpetuation of Limiting and Negative Behavior
- The Potential Positive Impact of a Caring, Responsible Family or Familylike Group as a Vehicle for Change, i.e., Group Participation

Seminar V. Physiological Effects of Substance Use/Abuse; Pharmacology (Drugs, Alcohol)

- The Effects of Different Drugs on the Body and on Overall Psychomotor Functioning
- Immediate Effects, Symptoms, Progressive Disorders, Adverse Reactions
- Pharmacology—Drug Similarities and Differences

Seminar VI. The Door's Substance Abuse Program as Compared With Other Approaches

- Prevention, Early Intervention, Intensive Treatment
- A Comprehensive, Individualized Approach
- The Role of the Drug and Alcohol Counselor in Treatment
- The Milieu
- Group Process and the Small Group Experience
- Other Programs, Modalities

Seminar VII. Reaching Adolescents Who Use Drugs

- Taking Substance Use Histories and Initial Interviews—Exploring Signs of Emotional Difficulties With Young People; Exploring Drug Use With Young People

- Symptoms To Know; Signs To Look Out For
- Referral Procedures and Hints

Seminar VIII. Arriving as a Community of Staff and Young People at a Clear and Consistent Message

- Exploration of Values, Attitudes, and Life Experience of Staff re Substance Use/Abuse Relative to Implications for Effective Treatment
- Feedback on Seminars—Suggestions, Questions, Concerns, Need for Additional and/or Continued Followup Training

(NOTE: This seminar may be extended beyond eight sessions, if warranted.)

Omaha Area Council on Alcoholism
Omaha, Nebraska

Marc Lund

Introduction

The Omaha Area Council on Alcoholism (OACA), in cooperation with other community agencies, developed the "Coping Group for Kids" in 1979. The group is designed to meet prevention, treatment, and education needs for children of alcoholics aged 15 to 19.

Efforts have been curtailed due to loss of funding. In the last 8 months we have copyrighted the group, trained a handful of leaders to facilitate the groups, revised materials, evaluated (nonscientifically) the group, attempted coordination of existing groups, and secured the services of professionals for evaluating the group. Our current efforts are directed at securing funds.

Program Description

A. *Session I*

The first session deals with attitudes children of alcoholics have toward alcoholism and alcohol abuse. Teenagers live with a great deal of inconsistency in their attitudes toward alcoholism and alcohol abuse. We have often heard the statements, "Let's party," followed by, "Did you hear his Dad's just a no good drunk?" We have incorporated a page in the session manual entitled "Situations," which describes 23 different life situations in which alcohol is involved. "Situations" asks that participants share their reaction to the different situations.

The participants are especially receptive to the information about the physical nature of the disease. Milam's theory was discussed, which led to doubts about the participants' own drinking behavior and the choices they were making.

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In order to provide stability, to help with communication, and to increase trust among the members of the group, the first session is one where norms are set and expectations are explained. Authier and Gustafson offer some very practical advice to leaders who wish to establish a secure environment for emotional growth. Their norms include:

- Setting the chairs in a close circle prior to the group meeting
- Starting on time
- Introducing new members
- Briefly reviewing the basic goals of the group
- Allowing only one person at a time to carry on the discussion
- Excusing self when late or when having to leave early, explaining why to the group members
- Directing members to talk to one another
- Pointing out the importance of staying on one topic
- Asking members to share common experiences and feelings

More specifically, the first session is important for establishing rapport and modeling good group skills. During this first meeting we ask the participants to attend faithfully for 8 weeks. We also talk about the necessary confidentiality of group interactions and learn the names and personal goals of each group member. We talk about what they hope to gain from the group, and we try to make the group personally meaningful to each member.

The homework for the first session is to complete a true/false test on alcoholism.

B. *Session II*

The second session covers the disease concept of alcoholism. Until children of alcoholics understand that alcoholics do not set out to be alcoholics, that alcoholics have no control over their drinking, and that alcoholics live with anger, guilt, and low self-esteem, they cannot be rid of their blaming, resentments, embarrassments, and frustrations.

The second session begins by having the participants talk about their response to the group. They share similar feelings of anticipation but are generally less nervous than they are at the first session. They are provided with the answers and rationale for each of the questions on the true/false test. In fact, this second session functions very much like a class. The leaders used OACA's "Early Warning Signs for Alcoholism" and the corresponding pamphlet for coalcoholics in conjunction with the short film "All Bottled Up." The pamphlets and film point out the

nature of the child's role in the illness, and the film offers some suggestions on how to cope with parental drinking.

The group members must complete a worksheet which requires them to define their problem.

C. *Session III*

The third session focuses on the family disease of alcoholism. We start the session with another brief glimpse at attitudes by looking at a person who appears to be an alcoholic, but who really is an individual with a collapsed lung. If participants in the previous week really listened to our description of alcoholism, they should be repulsed by what appears to be drunken behavior.

The third week begins with a discussion of how things are going at school and at home, and then proceeds to a discussion of the worksheet. This activity encourages the withdrawn participants to spell out their concerns in a less threatening way, and it forces the overly talkative members to zero in on areas of difficulty in their lives. Responses like "My problem is my father's drinking" are unacceptable. The worksheet directs attention to the problems of the group members, encouraging them to see themselves as different from the alcoholic and as able to define their own problems in order to change their behaviors.

The discussion of the worksheet leads very smoothly into a discussion of survival roles, and the members were encouraged to identify their own roles in the family.

When talking about alcoholism as a family disease, we incorporate Sharon Wegscheider's survival roles and OACA's "Early Warning Signs for the Co-Alcoholic." We also emphasize that family members cannot control the alcoholic or the alcoholic's drinking.

The members are given a self-esteem evaluation and a family illness test to complete during the week.

D. *Session IV*

The fourth session presents coping skills. Our intention is to give participants a chance to determine the problem, "own" any part of the problem, and determine what can be done. We include some role play that gives participants a chance to cope with the situations at home that cause the greatest anxiety.

During the fourth week the members take a more active role in the group. The self-esteem evaluation is scored, and the results are usually low for every participant. The leaders reassure the participants that their results are not unusual because their role

in the family reinforces that they would feel negative about themselves. The family questionnaire removes final doubts about the presence of alcoholism. In this session the group members participate in role-playing a family situation, using problem-solving techniques to aid the actors.

Because this session is the halfway point in their progress, the leaders asked the participants to write down for homework what they had found most valuable so far, things that they did not like, and things they wanted in the next 4 weeks. We find that the adolescents by this time have no reservations about stating their needs, likes, and dislikes.

E. *Session V*

In the fifth session we use the Jo-Hari window for an exercise in self-disclosure. Participants must list one asset and one liability they have perceived in the other participants. Then the participants must list those liabilities and assets that they perceive in themselves.

It is good to go over the assignments because members have had a chance to offer suggestions about what they need from the group. It is also an effective way to begin the exercise on self-disclosure. This exercise is very tricky because it has to be decided whether to collect all the papers and read them anonymously or to have the children read their own papers. We decided on the latter. We also participate in the exercise and are assessed by the group members. This is the closest and warmest experience we shared together, and the positive and negative feedback we receive serves as a gentle fourth step for some bruised egos. Much of the afternoon is spent reacting to the experience and realizing that we have become a cohesive, trusting group.

The members' homework is to write 20 positive statements about themselves.

F. *Session VI*

The sixth session is on communication. We incorporate a small amount of education about different levels of communication. Emphasis in this session is on recognizing and acknowledging feelings. We discovered an instrument called the "feeling wheel," which works well with these persons. We have participants express verbally and nonverbally different feelings from the wheel while others in the group determine which feeling is being expressed.

The homework is by far the most unpopular of any assigned.

Several of the participants are unable to finish it, and the honest discussion at the beginning of the session allows the leaders to make some observations about our widening channels of communication. The information provided on the different levels of communication leads to discussion about how participants talk to their parents. They look at why some of their interactions fail and why some are successful. The leaders introduce the concept of the "I-message" as a way to get feelings out without causing hurt or anger.

The exercise with the feeling wheel gives participants an opportunity to learn some new words they can use to identify their emotions, as well as verbal and nonverbal ways of conveying these emotions accurately.

In this session, we lengthened the meeting time from 90 minutes to 2 hours. The group is also provided with a copy of session VII to look over before coming to the next meeting. This is necessary because of the length of the movie in session VII.

The group is assigned to attend one open AA meeting during the week.

G. *Session VII*

Session seven is on confrontation. We use various definitions and ways to confront other people that we believe are constructive and exhibit "tough love." Role play is done, again using what participants have learned about coping, feelings, the disease of alcoholism, and confrontations.

This week the meeting is also lengthened to 2 hours to accommodate the discussion of the AA meeting and the film and to present confrontation skills. Most of the members have good experiences with the AA meeting.

The film, "Francesca Baby." [1] is about an adolescent who goes to Alateen, learns to cope, and then effectively confronts her mother about her alcoholism. It serves as a good introduction to confrontation skills and to some role-playing of family situations where confrontation is appropriate. At this time, the group members are uninhibited about sharing real-life situations with each other.

The homework assignment is to attend an Alateen or Al-Anon meeting. It also prepares them for the last meeting and for the fact that Al-Anon will help them continue to feel better.

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[1] Walt Disney Educational Media, Burbank, Calif., 1976.

H. *Session VIII*

Session eight serves as a review of the coping group experience. Emphasis is placed on where each participant started and how far he or she has come. Emphasis also is placed on the goals of the group and the continuing support from Alateen or Al-Anon.

The last meeting includes light refreshments and begins with a discussion of reactions to the Alateen or Al-Anon meeting. We discuss what they have learned, how they feel about the other members of the group, how their lives have changed, and what plans they have for the future. Saying goodbye is the most difficult part of the entire group experience because we have all been involved in important growth.

The program description for the coping groups was prepared by Cathy Desalvo, mental health educator, Nebraska Psychiatric Institute, and Teresa Rohren, counselor, United Catholic Social Services.

Leadership of the Coping Group

Leaders should be well versed on current alcoholism research, be aware of the concept of alcoholism as a family disease, and have some experience working with adolescents. The last requirement should not be overlooked. It is essential that the leader should be nonauthoritarian and create an atmosphere where the members feel free to say anything they want. It also is important for the leaders to participate in all the written activities with the group members.

The first coping group began in February 1977, and ran for 8 successive weeks. We began the group with four participants and two coleaders.

The leaders are experienced therapists who have worked with adolescents in psychiatric and social service settings. An effort is made to interview group members before they join the group in order to ensure success by arriving at a homogeneous balance in group makeup. The participants in the first group were highly verbal and had some insight into their problems. We explained briefly the aims of the coping group as we saw them:

- Provide the adolescents with information about alcoholism as a family illness
- Allow them to look at their own role in the family
- Alert them to the possibilities of alcoholism in their future
- Allow them to talk about emotions

- Provide them with some problem-solving skills
- Enable them to use confrontation techniques effectively

However, the overall goal of the group is to raise the self-esteem of each member. To measure the effectiveness of the experience, each participant is administered the Janis-Field Feelings of Inadequacy Scale before the first and after the last session. Although progress was made by each of the participants, the data are inadequate for conclusive reporting at this early stage.

The leaders found that the structure provided by the group outlines ensured some security to the group members and to leaders as well. Some chose to stay very close to the outline material while others wished to function more freely. Giving the outline of each session to the participants ensures the uniformity of information provided.

Assessment of Program Experience

Among our successes we include being selected for a meritorious award in prevention by the National Council on Alcoholism, and the training of a few facilitators. The groups are now available on a limited basis within the community.

Problems we have experienced are as follows:

- Loss of funding has directly affected our ability to work on this project.
- Recognition of the Omaha Area Council on Alcoholism's programs has contributed to ill feelings because others who assisted in the development of the project feel they are not getting proper recognition.
- Drop-out rate in the group is too high, and this rate indicates more revision is needed.
- At present there is no coordination among existing groups.
- Strategy for "where to go from here" has not been developed.
- A methodology for recruiting the groups has not been adequately worked out.

Key Issues

It is suggested that the following pertinent issues be discussed:

- Funding
- Coordination
- Evaluation and research
- Identification and recruitment of children
- Definition of what "successful" prevention is

Working With Children of Alcoholic Parents in an Outpatient Alcoholism Treatment Facility and in the Schools

Department of Community Mental Health Westchester County, New York

Ellen R. Morehouse, ACSW

The nature of intervention with children of alcoholics often is determined by the host setting in which the intervention takes place. The setting also influences the issues that emerge and success of the intervention. Therefore, the following discussion of work with children of alcoholics is divided into two parts. Part I focuses on working with children of alcoholics in an outpatient alcoholism treatment faciilty, and part II focuses on working with children of alcoholics in schools. The issues related to these settings are discussed in each part and summarized at the end of part II.

Part I: Working with Children of Alcoholic Parents in an Out-patient Alcoholism Treatment Facility

Introduction

In working with alcoholics and their nonalcoholic spouses at the Westchester Department of Community Mental Health alcoholism clinic (an outpatient alcoholism clinic), the staff recognized that the patients' children were not receiving any services despite the frequent concerns voiced by patient parents. Services were not provided to the children for two reasons. The first reason was that since the alcoholic was seen as the primary patient and, therefore, most responsible for the recovery process, serv-

ices were directed at the alcoholic. Collateral contacts or interventions with family members were made only when the alcoholic acknowledged some difficulty in his or her relationship with that person. Most frequently, the collateral contact was with the nonalcoholic spouse who became involved in marital counseling with the alcoholic.

The second reason why children did not receive services was that most of the staff felt uncomfortable in working with children or adolescents in a counseling relationship. Therefore, if an alcoholic client or staff member felt there was a need for a child to become involved in counseling services, the child was referred to a child guidance clinic or other service specifically oriented to treating children. Many of these referrals proved unsatisfactory because the staff of the children's agency lacked an understanding of alcoholism and its impact on children.

In 1974, the number of adolescents referred for treatment because of their alcohol-related problems increased dramatically. The realization that most of these adolescents had an alcoholic parent, coupled with the lack of appropriate agencies for referral of children of patients, led to the creation of the youth counselor position.

The youth counselor was required to have a background in child and adolescent development as well as clinical experience in counseling children and adolescents. The staff felt that the youth counselor could learn about alcoholism through readings, close supervision, and direct work with alcoholic patients. The youth counselor could then combine an understanding of alcoholism with an understanding of child development in order to work effectively with children of alcoholics and adolescent patients referred because of their alcohol abuse.

Population Served

The youth counselor at the Westchester Department of Community Mental Health alcoholism clinic saw approximately 65 children of alcoholic parents from July 1974 through January 1978. These children were seen in individual, group, and family sessions. They were from 5 to 18 years old, from lower- to upper-middle socioeconomic groups, and were seen from 1 to approximately 50 sessions. Some children had alcoholic parents attending the clinic, some had only a nonalcoholic parent attending, and some were seen at their schools at the request of school personnel. Some of these children had behavioral difficulties that concerned a parent or school authority. Others were not exhibiting any diffi-

culties and were seen to better understand their parent's alcoholism and/or recovery.

Program Description

A specific procedure was designed to lessen the patients' resistance to having the children seen. This procedure began at intake when the family history was obtained. All patients were asked routinely the names, ages, and grades of all children and then, matter-of-factly, the following questions: How are your children doing in school? Do you have any problems with your children? How do your children react to your drinking? Or, if the nonalcoholic spouse was coming for service, he or she was asked: How do your children react to your spouse's drinking? The answer to these questions led to a description of services the clinic offered to children via the youth counselor. The parent was told that as part of the treatment the children would be seen for a few educative sessions to better their understanding of their parent's drinking problem, their (the children's) feelings resulting from that drinking, and the recovery process. The parent was also told that this was done to facilitate the parent's recovery by lessening the chance of the children's behavior interfering with the recovery process and to help the children if their reaction to the drinking had negative consequences.

Parents were introduced to the youth counselor and given suggestions about how to prepare the children to come to the clinic. In almost all cases, parents were very relieved that "someone" was going to see the children because the newly sober parents had tremendous guilt about their past parenting and the effects of their drinking on the children. Usually they also shared with the youth counselor their concerns about the children and problems that existed at home, at school, or with peers. In this first brief meeting, parents also were told what would happen during the first visit when the children accompanied the parents.

At the first visit (depending on whether there were one or more children and upon the variations in their ages) the child(ren) and parent(s) were seen together. The child was asked if he or she knew where he or she was and why. The parent was then asked to explain the situation to the child if the child had said he or she didn't know or to confirm what the child said if the answer was positive. The youth counselor further clarified the circumstances by explaining to the child why he or she was there. The parent was then asked to describe how he or she thought the drinking affected the child and what the child saw

and worried about that was related to the drinking and might be upsetting. If the parent had difficulty with this, the youth counselor went through a checklist of possible alcohol-related behaviors to which the parent could say "yes" or "no." A partial list of such questions is: Has your child seen you pass out? Has your child seen you have a blackout? Has your child seen you get sick, throw up, or lose control of your bladder or bowels? Has your child seen you become violent or angry inappropriately? Has your child seen you involved in any inappropriate sexual or criminal behavior? Was your child ever afraid you were going to die? The child was then asked if he or she could think of anything else.

This procedure was followed so the child would feel less inhibited about discussing his or her parent's drinking. By having the parent state what had happened, the child felt the parent was giving permission to discuss the child's concerns and, therefore, didn't feel that he or she was "tattling" or "ratting" on the parent.

The youth counselor then explained to the parent and child that the child would be seen alone for a few "educative sessions" and the parent would be seen alone to give a developmental history. Each agreed that what he or she said to the youth counselor would be confidential unless the counselor was given permission to discuss it with the other person. The child was then seen alone for approximately 15 to 30 minutes.

In this first session, the youth counselor demonstrated an understanding of how children with alcoholic parents feel. This was done in order to overcome each child's initial skepticism and to establish trust. The child was made to feel valued and was given an opportunity to express concerns about the parent's drinking, the home situation, or anything else. Then information about alcohol, drinking, and alcoholism was shared as it related to the child's concerns. The information was given to correct any of the child's distorted perceptions. Better understanding of alcoholism and the parent's behavior usually resulted in fewer painful feelings, worries and feelings of responsibility and anxiety, and enabled the child to feel less burdened.

Once the child had a better understanding of the alcoholic's behavior, the child's own behavior was examined and discussed. Ways of improving interaction with parents were discussed and included concrete solutions for coping with the drinking as well as ways for improving relationships.

Implementation of this format varied and was either con-

densed into as few as two sessions or expanded. The nature and duration of the sessions varied greatly depending on many factors such as the age of the child, the number of children in the family, the severity of the parent's drinking problem, and the existence of emotional problems in the parent or child. The choice of modality also varied greatly. For example, play therapy and activities also were used.

If children denied the existence of concerns or were unwilling to discuss them, they were seen only twice to get information that "maybe they would need in the future" or that might help "a friend" with an alcoholic parent. Their defenses were respected, and a followup session was often scheduled 5 to 6 weeks later.

Family sessions were scheduled only after the youth counselor had established the child's trust and the child had a better understanding of the parent's alcohol-related behavior and his or her feelings. Family sessions were particularly useful in repairing faulty communication and interactional patterns, helping the child and alcoholic parent feel more comfortable with each other, and making the alcoholic parent feel more confident of his or her ability to be a parent.

Assessment of Program Experience

The program's most important success was in involving the children of patients. The design of the intake process described above served effectively to reduce the resistance of parents to the entry of their children into counseling.

The program at the clinic was extremely successful in reducing anxiety in the children that were seen. Most of the children had never discussed their parents' drinking with anyone outside the family. As a result, there was a lot of confusion regarding the drinking and the resulting inconsistent alcohol-related behavior. Most of the children's anxiety stemmed from a combination of the following factors:

1. The children felt responsible for their parents' drinking either directly or indirectly. They sometimes were told, "If you wouldn't ————, I wouldn't drink." If they were not directly implicated, they would feel responsible for causing the parent to get angry, and the anger was handled by drinking. Or, they were told by the nonalcoholic parent when the alcoholic was abstinent, "Don't upset your father." This made the children feel that the nonalcoholic parent felt that the children's behavior could be responsible for the drinking.
2. The children felt that alcoholic drinking equaled not being

loved. They felt, "If Daddy really loved me, he wouldn't drink." They felt hurt by the actions of the alcoholic that were often characterized by broken promises or inadequate attention, affection, or material goods. The resulting feeling was, "If parents loved their children, they wouldn't hurt them."

3. There was anger at the nonalcoholic parent for not protecting them from the alcoholic's violence, not getting a divorce, not lessening their responsibilities of having to assume parental roles. Frequently the anger was because the children perceived the nonalcoholic parent as being responsible for the alcoholic's drinking. "If Mom wouldn't nag Dad so much, he wouldn't drink."

4. The children had varying degrees of fear that the alcoholic would get hurt, sick, or die as a result of being intoxicated. Worrying that "Mom would fall asleep with a lit cigarette and cause a fire," or that "Dad would have a car accident on the way home from work," sometimes made it impossible for the children to concentrate in school. In extreme cases the children would want to stay home from school to take care of the parent.

5. In situations where the alcoholic parent was more permissive or affectionate while intoxicated, the children preferred the parent drinking but felt guilty about wanting the parent to drink.

6. Children always felt confused by the difference between the "dry" behavior and the "drunk" behavior. (Not understanding blackouts proved to be very frightening. Witnessing blackouts at first made the children feel the parent was "going crazy." The children also had angry feelings if things were unfairly blamed on them as a result of a parent being in a blackout.) Confusion also resulted from not knowing how the alcoholic really felt. Many older adolescents believed that alcohol acted as a truth serum. One teenage girl was punished for coming in late when in fact she had been in on time and had spoken with her alcoholic parent when she arrived home. Another girl was called derogatory names and was accused of being promiscuous by her father when he was intoxicated. When he was "dry," he would frequently comment on how proud he was of her. The unjustified criticisms or accusations by the alcoholic almost always left the children so angry, frustrated, or sad it was impossible to study or do homework. These same feelings also resulted if the verbal or physical abuse was directed at the nonalcoholic parent. If the children also felt responsible for causing an argument between the parents, these feelings were intensified.

7. The children's confusion over inconsistent behavior made them reluctant to bring friends home because they never knew what to expect. This inhibited the development of close peer relationships. Even young children are sensitive to social reciprocity; and after so many times of visiting at a friend's house, children feel obligated to reciprocate. Many children avoided close friendships in order to avoid having to invite friends home. The usual pattern was having one close friend who knew of the parent's alcoholism. Many children also felt tense right before returning home or right before the alcoholic was supposed to arrive, again because they did not know what to expect.

8. Once the children were old enough to realize that drinking alcohol was frowned upon by others or was "different," there was always shame and embarrassment. Many children were willing to take criticism or punishment from friends or teachers rather than "expose" their parents' problem. One elementary school-aged girl was yelled at by her classroom teacher for not bringing in sneakers as required. She accepted the punishment rather than tell the teacher that her mother was not able to buy the sneakers because she was on a binge. Contributing to children's sense of shame is the attitude of the nonalcoholic parent who tells them not to discuss the drinking with any one outside of the home. The nonalcoholic's attempt to "cover up" the drinking also lets the child know that the drinking is to be kept secret. When this is done, even with friends and family members, the children get a clear message of "Mom's drinking is so terrible, we can't even tell Grandma!" In the children's minds the drinking is then put into the same category as a crime. Several high school students believed that some of their peers' parents did not want their children to go out with them because of their parents' drinking. Counseling sessions addressed these factors in age-appropriate ways with each child.

A separate youth counselor to work with the child, to be an advocate for the child, and to see the parent for occasional parent consultation, while having a separate counselor for the parent, was particularly effective for several reasons. First, the needs of the child and the needs of the parent often conflicted. Second, many times both alcoholic and nonalcoholic spouses were too emotionally needy to share their counselor. Third, many of the staff members were particularly skilled in working with alcoholic adults and their nonalcoholic spouses, but were not skilled and/or comfortable in working with children. Fourth, the children's trust was greater when they had their own counselor.

This procedure, while effective, could be improved in the following ways. First, the child's attendance at sessions depended on the parent's attendance (unless the child was able to get to the sessions alone). Many times if a parent had a "slip," the child was unable to attend a session when it was needed most. Therefore, alternative means of transportation for children and alternative sites for sessions should be planned.

Second, despite stated administrative support, there were varying degrees of staff commitment to the program, which resulted in uneven referrals of patients' children. It was found that staff members strongly committed to the program involved a higher proportion of their patients' children earlier than staff not strongly committed to the program. This situation could have been improved by working through with some staff members their reluctance or discomfort with the referral procedure or program.

Part II. Working With Children of Alcoholic Parents in a School

Introduction

In 1976 a 10-week group for high school students with alcoholic parents was created at the Westchester Department of Community Mental Health alcoholism clinic. This group provided supportive educative counseling sessions that focused on helping members better understand and cope with their parents' alcoholism and their resulting feelings. Some group members were children of parents attending the clinic, whereas others were referred by guidance counselors from nearby high schools. All participants were from middle-income families and attended voluntarily. This group was so successful, in terms of the participants' reports of better understanding of parents' alcoholism and behavior, decreased anxiety and depression due to parents' alcoholism, and improved relationships with the nonalcoholic parent, that one high school that had two student members formed a similar group in the school.

Also, during the 1976–77 school year, several workshops were conducted by the youth counselor for interested school personnel, i.e., guidance counselors, school psychologists, and school social workers on how to identify and intervene with adolescent problem drinkers and children of alcoholic parents. A school administrator at one of the workshops expressed concern about the large number of students with these difficulties and the extreme

problem they presented for him. Since this rural school was quite far from any existing alcoholism services or even from Alateen meetings, it was decided that the youth counselor would spend a full day at the school for each of the remaining 10 weeks of the school year.

Pilot Projects: Description and Program Development

Five students with alcoholic parents told pupil personnel staff members about their parents' alcoholism. These five students were informed by the staff member about a group that would be forming at school to help students with alcoholic parents. All five students agreed to meet with the youth counselor the first day to find out how the group would be conducted and what its purpose would be. In this first meeting, the youth counselor demonstrated understanding of the feelings that are common to children of alcoholic parents.

The students were given an orientation and informed of the purpose of the group, the need to keep confidential the identities of other members and what they said, and the time and place of the group (which could be shared only with friends who had alcoholic parents and wanted to join). They also were told that the principal would know they were participating, that participation was strictly voluntary, and that they had the right not to speak if they didn't want to. They were also prepared for the nervousness they would feel, told to remember that all the other participants would be feeling the same way, and were invited to bring friends who also had alcoholic parents. Students also gave a brief description of the specific situation in their homes and how it affected them.

All five students brought a friend with an alcoholic parent to the first meeting, and four more students with alcoholic parents came to the second meeting before membership was closed. This group was considered extremely successful by student participants and the school administration. The results described in the clinic group above were repeated and, in addition, attendance at school improved, while disciplinary referrals for lateness and cutting classes decreased in number.

Also, by the end of the session, all participants were able to discuss the group with their nonalcoholic parent. In several cases, this resulted in the nonalcoholic parent's willingness to attend an Al-Anon meeting for the first time, and enabled the adolescent to attend an Alateen meeting held at the same time.

The group members were all female, from lower-middle- to upper-middle-income families, and did not abuse alcohol themselves.

Seven of the group members also told their alcoholic parent of their participation. None of the students, much to their surprise, received negative reactions from the alcoholic parent. Instead, both alcoholic and nonalcoholic parents' responses ranged from approval and curiosity to indifference. This group was reinstated the following school year (1977–78) by a social worker from an adolescent agency who was trained and supervised by the youth counselor. This new group retained all but two of the members (who had graduated) from the preceding group, added new members, and lasted for 20 sessions.

This same group was reinstated in the 1978–79 school year by a school social worker who was added to the school's staff. As in the previous year's group, they received some supervision from the youth counselor, new members were added, and nongraduating members continued.

In this same school, six senior boys from middle- and upper-middle-income families were referred individually to the youth counselor at the beginning of the final marking period and were told that if they did not keep the appointment, they would be suspended. All six boys had repeatedly come to school intoxicated, had higher than average rates of absenteeism and lateness, and had lower marks than in past marking periods. In the first session, all were generally hostile and felt that they were being unfairly singled out "because there were a lot of other students that drank just as much." Instead of dealing with whether they should have been referred, the youth counselor focused on the school's concern about them and explored areas that were of concern to the boys themselves, such as parents, friends, teachers, etc. All the boys (some reluctantly) agreed to return the next week to discuss things further.

In the second session, all six boys were much less hostile and more open in sharing information and feelings. Five of the boys had alcoholic fathers. The sixth student asked if he could stop coming to sessions because he had decided not to drink excessively any more and, therefore, didn't need to attend. He agreed that this information could be shared with the principal who agreed to "give him a chance."

By the third session a therapeutic alliance was formed with five of the boys. They were able to discuss problems they were having and to agree that their drinking was excessive and con-

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tributed to their problems. They decided that they wanted to improve their ability to cope in specific areas and would try to stop or significantly decrease all alcohol use temporarily. These five students missed no more than one of the remaining seven sessions. All significantly decreased their intake of alcohol to moderate amounts on weekends only. Their attendance and grades improved for the last marking period.

This experience replicated experiences at the alcoholism clinic; patients initially mandated to treatment, and at first hostile and resistant, usually were able to become motivated for treatment and form a positive therapeutic alliance. The experience at this school also convinced the school to hire a social worker, despite severe budget cuts in other areas.

In September 1978 another school was selected as the site to implement the student assistance program on a limited basis. This school was a suburban high school of approximately 1,000 students from middle- to upper-income families. The youth counselor spent 1 day a week seeing students with alcoholic parents, students referred because of suspected alcohol and drug abuse, and students with school-related behavior problems. Of the 45 students who were referred, all but four had an alcoholic parent or were students with inappropriate, limited, or episodic use of alcohol. Students were seen individually or in group sessions for 1 to 20 sessions. Many were referred to treatment services toward the end of the school year. In addition, 10 students were self-referred as a result of their friends' involvement.

The administration was pleased by the positive response to the program by students, parents, and faculty. The existing pupil personnel staff were pleased by the added resource and increasingly asked for consultation and made referrals. The superintendent requested a new part-time position in the school budget to continue services after the pilot project ended.

These three successful pilot projects have resulted in numerous requests to the Department of Community Mental Health from school districts for help in providing services to children of alcoholics and to students who abuse alcohol.

These pilot projects and the positive experience at the outpatient alcoholism clinic have served as the basis for a new program that began in September 1979. The program is called the Westchester County Student Assistance Program, is funded by the New York State Division of Alcoholism and Alcohol Abuse, and is an adaptation of the employee assistance program model.

The student assistance program places a student assistance counselor in each of six diverse sample high schools in Westchester County for an entire school year. The six student assistance counselors have master's degrees in social work and have clinical experience doing counseling with adolescents. They participated in a 6-week intensive training period to learn about alcoholism and how it affects the children of alcoholics, as well as to learn about adolescent alcohol use and abuse.

The student assistance program is considered a prevention/early intervention program that provides supportive, educative group counseling sessions to students with alcoholic parents as well as individual or group sessions to students who are abusing alcohol or drugs.

Assessment of Program Experience

The school-based services to students with alcoholic parents met previously neglected students' needs by providing an understanding of their parents' alcoholism and how it affects them and by improving their ability to cope. The group sessions reduced the members' feelings of isolation and stigma.

The fact that these groups were held in and during school, that participation was not contingent upon parental permission, and that the school was willing to let students miss classes to participate, were key factors in the successful outcome of the programs.

These groups were also seen as a preliminary step to Alateen. Most Alateen members have at least one parent who is already in Alcoholics Anonymous, Al-Anon, or some form of treatment. For the vast majority of children with active alcoholic parents, Alateen participation is unlikely. This is especially true in rural or suburban areas where public transportation is often inadequate. It is almost impossible for 13- to 18-year-olds to go to a meeting at night without their parents' knowledge. If the parents of the children in the groups were not seeking help for lack of some form of preparation, the groups provided that preparation.

Perhaps the most crucial factor in the development and success of the school-based program was the support of the school administrator and pupil personnel staff. In both pilot projects and now in the six schools implementing the student assistance program, the school administrators and pupil personnel staff believe that students with alcoholic parents are an appropriate target group for specialized services. This recognition arises from the realization that many of these students experience

school-related problems in the areas of academic performance, truancy, lateness, and behavior. More importantly, many students who abuse alcohol and/or drugs also have alcoholic parents.

In trying to develop school programs for students with alcoholic parents, it was possible to see in many school districts that while most school administrators felt there was a need for services, they were sensitive to the issues that would inevitably arise and were reluctant to develop such services for fear of negative parental reaction. They felt more comfortable initiating programs for students with alcoholic parents if and when the program could be the "quiet partner" to a program focusing on interventions with students who abuse alcohol and/or drugs.

The most serious issue and impediment to the development of the school-based programs is the issue of parental permission. While most school administrators realize that it is unrealistic to expect such students to obtain parental permission because of family dynamics, they are still reluctant to allow the students to become involved in services without parental permission. The school and the students are, therefore, caught in a double bind. However, successful experiences and lack of parent opposition in other schools help administrators overcome their reluctance.

Unfortunately, if a parent protests a child's involvement in services, the school legally has no choice but to follow the parent's wishes unless the school decides to get a court order, which is almost never done.

A second problem arises in having licensed alcoholism treatment agencies or children's agencies provide services to children of alcoholics who are minors and without parental permission. In both pilot projects at the schools this was the area where improvement was needed. In both groups there was a need for ongoing treatment for some of the students, yet in cases where the parents had consented to the child's involvement in the group, they were unwilling to follow through on additional services for the child. In cases in which students did not advise the parents of their participation in the group, they were also unwilling to obtain parental permission for additional services. As a result, these students were not able to obtain the additional services needed. This problem is even more acute for children in elementary school.

A third area of concern is the issue of reporting child abuse in alcoholic families. While this procedure is required by law, the child-abuse investigating agency often is uninformed about the dynamics in the family with an alcoholic parent, and, as a

result, the interventions are not appropriate. The conflicting relationship between Federal confidentiality regulations governing treatment of alcoholics and child-abuse reporting procedures often further inhibits provision of services.

Summary of Issues

The following issues were discussed in the context of providing services to children of alcoholics in two different settings: the outpatient alcoholism treatment agency and the school. These issues are:

- The lack of staff at alcoholism facilities with training in working with children and adolescents
- Resistance of staff members at an alcoholism facility to place importance on supportive services to children of patients
- Lack of knowledge among the staff of children's mental health services about alcoholism and how it affects the family
- Need to obtain parental permission in treating children of alcoholics at licensed alcoholism treatment or children's agencies
- Conflict between confidentiality regulations for alcoholism treatment
- Child-abuse reporting and followup services
- Hesitancy of the schools in initiating services to students with alcoholic parents

New Directions: The Family Center Youth Program, Human Relations Center, Inc. Santa Barbara, California

Wayne Muller

Introduction

The Human Relations Center, Inc., is a private, nonprofit organization that has been serving the community of Santa Barbara for the past 7 years. The agency currently sponsors three major projects:

- The Family Education and Counseling Center. This project is staffed by California State licensed psychotherapists who provide professional, clinical services on a sliding fee schedule. Individual and group counseling, family therapy, and couples counseling are provided at a reasonable cost to individuals and families in the community.
- The Isla Vista Human Relations Center. This center, located in a high-density, low-income community, is staffed primarily by community volunteers who are recruited, trained, and supervised by professional staff. These volunteers provide free counseling and outreach services to those in need.
- New Directions: The Family Center Youth Program. This pilot project focuses on adolescents and their families who have alcohol-related problems. Staffed by professionals, New Directions provides intensive family therapy and outreach services to alcohol-abusing adolescents identified by law enforcement and community agencies, with a special emphasis on the identification and treatment of children of alcoholic parents.

The New Directions program began as an expanded version of an adolescent alcohol treatment and prevention program. When it was first developed in 1976, the adolescent alcohol pro-

gram worked primarily in the schools, providing alcohol discussion sessions for local junior and senior high school students. The discussions with these students focused on the chemical nature of alcohol, drinking behaviors among the students, whether students did or did not drink and why, how to determine if someone in their life had a problem with alcohol, and possible strategies for dealing with alcohol abuse. As the program's exposure increased in the schools and the community, referrals of specific teenagers were made for alcohol treatment by probation officers, school personnel, and community agencies.

In response to these referrals, a treatment and prevention program was developed for alcohol-abusing adolescents that included individual, group, and family counseling. Many referrals came from schools, courts, and other juvenile institutions. The response from the community was enthusiastic, and the referrals continued to increase.

By mid-1977, the focus was more and more on the families of the young people who were entering the program for treatment. It became increasingly clear that teenage alcoholism was, indeed, a family-centered problem. Although the family disease of alcoholism as it pertained to the treatment of adults was frequently discussed in the extant literature, the necessity of applying these same principles to the treatment of alcohol-abusing adolescents and their families became obvious.

At the same time, it was found that among those adolescents referred for alcohol treatment, a large majority—nearly 80 percent—had at least one parent who was an alcoholic. This constant flow into the program of young people with alcoholic parents resulted in targeting this group of adolescents as a high-risk group in need of specific attention. Subsequently, an intensive program of professional therapy involving the entire family of the young person in treatment—brothers and sisters as well as parents—was developed. The program was designed to reduce the risk of alcohol abuse among all the siblings within the alcoholic family. This, in part, was the birth of New Directions.

Population Served

The adolescent alcohol program provides services to:

- Adolescents between the ages of 13 and 18 years who are having problems related to their abuse of alcohol. Most of these young people have been arrested on alcohol-related offenses and are having problems with school and/or family.
- Adolescents who are children of alcoholic parents. Many of

these young people are having problems with their families, their friends, their schools, and the law.

- Families of the young people in treatment. We place a high priority on involving the family members in the treatment of the young people in our program. This especially involves treatment of the younger siblings in the alcoholic family as a way to prevent alcohol abuse in later years.

We provide prevention services to:

- Students in schools throughout the Santa Barbara area through our 3- to 5-day classroom presentations.
- Groups of interested young people who wish to explore their own lives as they relate to the use and abuse of alcohol.

We provide outreach and consultation services to:

- Probation and law enforcement personnel who are interested in developing their capabilities to better identify and deal with the alcohol-abusing adolescent.
- Teachers and other school personnel who are eager to develop their skills in presenting alcohol information and referring students with alcohol problems for treatment.
- Community agencies and youth workers who are interested in expanding their knowledge and capabilities in the area of teenage alcohol abuse.
- Students and interested young people who come to us for training and supervision so that they may set up student-run alcohol and counseling programs.

Program Description

The philosophy underlying our family therapy program is based upon a few key concepts. The first is that alcoholism is very much a family-centered problem, regardless of whether the alcohol abuse is found among the parents or among the children. It has been found that the structure of an alcoholic family system inevitably involves a common set of family interactions: denial, persecution, rescuing, victimization, self-destruction, and blaming. These factors combine to foster the continued abuse of alcohol within the family system. The treatment efforts of this program are designed to: (a) make these processes explicit to all family members and (b) realign the structure of the family system to enable all family members to work together to deal with the presence and/or absence of alcohol within the system.

To achieve this end we use a family systems approach in the therapy sequence. As pioneered by Ackerman (1961) and later developed by Lederer and Jackson, Haley, Satir, and others,

family systems therapy has become an effective tool for the realignment of the structure of the often self-destructive alcoholic family. It has been found that the concept of "homeostasis" or family balance (as originally developed by Lederer and Jackson) is an effective construct that accurately describes the rigid patterns of interaction that frequently occur in the alcoholic family system. The persecution-rescuer-victim triangle developed by Karpman closely parallels the description of homeostatic balance within the family. Consequently, therapy sessions are used to help the family understand how the homeostasis within their family system tends to keep the family in a state of pain and confusion, fostering and indeed supporting the drinking behavior of the alcoholic in the family.

In addition, techniques developed by Haley are used to uncover the metarules that lie beneath many of the explicit interactions between family members. These metarules are implicit, unspoken rules present in the family, many of which tend to maintain the homeostasis (e.g., "Don't talk about Dad's drinking," "If you're upset, keep it to yourself," etc.). A primary focus of therapy is to help the family recognize both the presence and the function of these implicit rules. This often results in a discovery of a paradoxical double bind (Haley 1963, Bateson et al. 1963) within the family system, a situation that often serves to maintain homeostasis by setting up interactions in which everyone "loses" during family interactions (e.g., metarules, "Don't confront Dad about his drinking."). There are two possible responses to this implicit message: (1) to do nothing, in which case Dad continues to drink and family members experience pain and frustration, or (2) to confront Dad's drinking, which is breaking an implicit family rule, upsets Dad who then drinks more frequently, resulting in pain and frustration among family members. In each case, family members "lose" in the family interaction. By making these metarules explicit, the therapist can help family members confront their fear of change.

The third principle of this family systems approach involves a strong commitment to the concept of positive intentionality. This concept, explicated by Kirchenbaum and Luthman (1974) and Satir (1964), is based on the basic belief that families have the power to make positive changes in their lives. Through positive intentionality, therapists work under the basic assumption that each person is doing the best that he or she can, given the tools available, to work together with the family. This approach is in direct contrast to many contemporary intervention strate-

gies, which often identify one person (or group of persons) as the sole agent preventing the harmonious operation of the family unit. This often results in the "scapegoating" of an individual, requiring extended periods of parent education to correct "faulty parenting" or intensive individual therapy to help an acting-out child to "adjust" to his family.

As an alternative to the "identified patient," the family is viewed as a homogeneous group of people who feel and behave as a unit. If one person in the family is in pain, it is a signal to the therapists that the whole family is in pain. The resulting fear and confusion within the family is attributed not to the identified patient but rather to the frustration that each family member feels as a result of trying to "make it better" and somehow not succeeding. The goal of therapy is to help the whole family to develop new ways of working together, enabling them to make significant progress toward their goals as a family.

This positive approach toward family therapy becomes extremely attractive to both parents and children in alcoholic families in that it supports the positive intentionality of each and every family member. As a result of this support, one encounters little of the apprehension and denial often found in families referred to a community agency for treatment. Approximately 90 percent of the parents of children in this pilot project ultimately agree to participate in family therapy.

Although this project is in a pilot stage, preliminary results have been extremely encouraging. Data collected on approximately 50 program participants over the past 12 months indicate an average reduction of 87 percent in the numbers of alcohol-related arrests among program participants. The results are based on a comparison of the arrest records of clients before entering teatment with the arrest records 6 months after leaving the program. Although further followup is needed for verification, the results indicate that this family therapy approach is a definite factor in the prevention of alcohol-related acting-out behaviors.

The Program and the Community

In addition to developing a secondary prevention model utilizing family intervention techniques, an effective identification and referral system utilizing the resources of community agencies is being established. Working closely with alcohol treatment facilities, school faculties and administrators, and law enforcement and juvenile justice personnel, a process has been set up

for the early identification and referral of children of alcoholic parents to this project.

Through a series of workshops and consultation sessions with community members, community awareness of the problems encountered by children of alcoholic parents has been increased. The focus of these workshops has been on the description of the dynamics of the alcoholic family system, the issue of the disproportionate distribution of children of alcoholic parents within juvenile institutions, and the overt symptomatology exhibited by certain members of the target population. As a result of this process, referrals have been received from teachers, counselors, probation officers, judges, alcoholism treatment staff, and parents throughout the community.

A close working relationship also has been developed with members of both Alcoholics Anonymous and Al-Anon. Many Al-Anon parents have been referring children to the program for individual and group treatment. Many of these children's parents ultimately participate in the family therapy project. Working with AA has enabled the development of an effective system of cross-referrals, with members referring families to the program and project staff referring alcoholic parents to AA for ongoing support.

Due to the effectiveness of this system, referrals to our program have increased in number to the point that they exceed the handling capacity of the staff. The program currently maintains a waiting list of between 3 and 4 weeks that continues to grow as referrals increase.

In summary, the progress of the pilot program indicates the presence of a very real need for services to the target population. Preliminary results seem to show that this program philosophy and project design combine to produce positive change among the children referred to the program. The preventive nature of this type of service appears to be very effective among the high-risk group targeted by the project, in that the intervention occurs at an early stage in the development of alcohol abuse among children of alcoholic parents.

Assessment of Program Experience

A. *Program Strengths*

Identification. We have developed an extensive community-based identification and referral system utilizing teachers, counselors, juvenile justice personnel, and Al-Anon and Alateen. We also

have involved the children themselves in the identification of friends and family.

Positive Intentionality. Utilizing a therapeutic philosophy based on a belief in the intrinsic strength and wisdom of each and all of our clients, we create a comfortable atmosphere of health and well-being that is both attractive and accessible to parent and child alike.

Family-oriented Approach. Viewing the alcoholic family as a balanced system allows us to direct attention away from specific "patients" in the family—whether they be the alcoholic parent or the acting-out child—and onto restructuring a creative homeostasis that supports and encourages the realistic resolution of conflict, pain, and developmental struggles within the family.

B. *Program Weaknesses*

Identification. The late development of some of the symptomatology found in children often impedes early identification. We need to explore the dynamics of change within children as they move through their developmental processes.

Parental Involvement. While we have a relatively high rate of success by including parents in the treatment process, the single factor that inhibits total family involvement is the continued drinking behavior of the parent. We may well find that we must treat the parent with the same dedication with which we treat the child.

Residential Needs. In the absence of parental sobriety, it sometimes becomes necessary to consider the option of extra-home placement for the child of the severely disturbed alcoholic, particularly when that child is beginning to wrestle with the spectre of alcoholism in his or her own life. The lack of such residential facilities on a community- and state-wide basis occasionally has been a very real detriment to the successful treatment of the child.

Viable models now are needed that are designed to treat alcoholism in the context of the family. Literature on alcoholism indicates many efforts to work with members of the family as a group of individuals, as opposed to treating them as a family system that includes alcoholism. It has been found that sobriety does not necessarily result in attitudinal change on the part of the alcoholic or the family members regarding the causes of

alcoholism. In addition, sobriety does not necessarily result in a healthy family system. Therefore, there is a need for a cost-effective model based on brief family therapy, as opposed to long-term therapy, that will result in the creation of a healthy family system and will prevent alcohol-related problems among children of alcoholic parents.

Key Issues for Discussion

A. *Identification*

The task of identifying children of alcoholics seems, at first glance, to be a simple one. Certainly all one need do is identify the alcoholic parent and the children will follow like lemmings into a sea of sophisticated treatment and prevention clinics. Unfortunately, there are several factors that prevent this scenario, including the alcoholic's inclination to denial during the drinking phase and insistence on anonymity while under treatment. Those who reach hospitals or rehabilitation facilities where children might become involved constitute a very small percentage of the population of alcoholic parents. There remains a large percentage of children whom we must seek by employing new and creative methods of identification. A few of the more promising techniques that we have used with some degree of success include:

Awareness of Family History. Given that children with alcoholic parents are at risk for various legal, social, and emotional difficulties, it becomes important to recognize youth workers and professionals in the community—teachers, probation officers, school counselors—as potential allies in our quest for appropriate identification and referral. We have found that if educated to the importance of the child's family history, they can, with a minimum of effort, easily and comfortably determine the nature of the parent's drinking patterns.

Personality Description. Just as there is no one alcoholic personality, so there is no single personality type associated with children of alcoholics. However, we have found that most of these children develop methods of survival in response to the alcoholic family that can be loosely classified under the following broad categories:

- Playing Stupid. These children, in response to the stress, confusion, and implicit demands coming from the family to take responsibility for their pain, choose to "play stupid" in order

to avoid the morass of interpsychic pathos and to come away intact. These children, while not "stupid" by any true definition of the word, frequently are classified as "slow" or "learning disabled" as a result of their particular survival strategy.

- Acting Out. These children often act out in various ways in order to distract the family from the painful task at hand. Their acting out also serves as a unifying factor, enabling the frequently polarized parents to join forces in order to deal with the issue of "Johnny's problem." These children often come to the attention of juvenile authorities whose indepth exploration of family history often uncovers alcoholism and/or alcohol abuse in the family.
- Debating Team. These children, by far the most difficult to identify in earlier stages of development, quietly accept a good deal of responsibility for the pain in the family. They often become super-responsible, at home and at school, where they excel in intellectual pursuits, enjoy a high degree of popularity (being extraordinarily adept at pleasing the people with whom they come in contact), and assume positions of leadership (e.g., the captain of the debating team). In effect, an all-purpose "good kid." Their only symptomatology is internal, difficult to identify, and evident only to themselves as part of a grandiose network of self-denial. The potential for alcoholism here is very great, with the disease developing in later years as the process of self-denial becomes a burden too great to bear.

The more we understand the profound impact of the alcoholic family and the subsequent survival techniques employed by these children, the more successful we will become in helping others in the community become attuned to the subtle behavioral signals available to them in identifying the children of alcoholics.

B. *Treatment*

Two basic categories of questioning spring to mind: "What?" and "How?"

Specifically, what are we attempting to treat? The literature is rife with documentation of social, legal, emotional, and alcoholic-related problems for which children of alcoholics are at risk. Do we limit our treatment goals to the elimination of those problem areas specifically associated with alcoholism? Or is it more legitimate and, indeed, advantageous to expand our therapeutic vision and develop a strategy that addresses the phenomenolgy of the whole person and the spectrum of issues confronting the child?

Once we have determined what we will be treating, how do we

proceed with treatment? Several of the problems cited above that are observed in the child of the alcoholic are inherently contexual in both etiology (i.e., they are identified through their unique position in a troubled family system) and symptomatology, i.e., they have been found to be at risk for various social, legal, and relationship difficulties as defined in a social or legal context (Miller and Jang 1977; NIAAA 1974). This would seem to indicate that interactional models of therapy would prove most fruitful in the successful treatment of the child of the alcoholic. Indeed, family therapy in a variety of forms has been used with positive results in the treatment of the alcoholic by Steinglass, Bowen, and others. Why, then, can we not apply the same interactional principles in the treatment of the child in a family context? And yet there is increasing biological evidence that indicates the presence of a chemical and/or genetic factor in the development, if not the transmission, of alcoholism. Given the apparent validity of each construct, it would appear that we are faced with a therapeutic chicken and a theoretical egg: to determine which came first and which carries less importance in the development of an effective strategy to incorporate the wisdom of both.

C. *Prevention*

The verb "prevent" implies the existence of an object or occurrence that is to be prevented. While the concept of "prevention" has enjoyed a considerable popularity in therapeutic circles in recent years, this widespread use of the term has, all too frequently, resulted in a gradual erosion of any definitive statement about the object to be prevented. Marketed as a panacea of sorts for such diverse social and personal ills as alcoholism, juvenile delinquency, and reckless driving, the conceptual goal of "prevention" often seems to run the risk of becoming an ambiguous and amorphous hydralike creature that threatens to dissipate any effectiveness of purpose with its overwhelming diversity.

Consequently, it is incumbent upon us to specify our goals, choose from a multitude of documented attitudes and behaviors for which the child is at risk and determine which of these we are predisposed toward and capable of preventing. There are several factors beyond our grasp, factors that have been laid before us a priori over which we, like Job, have little control.

The first of these factors is that we cannot—barring the total eradication of the disease of alcoholism from our culture—prevent children from being born to alcoholic parents. The very ex-

istence of alcoholism in the adult population guarantees that some children will have alcoholic parents. Secondly, it would be unwise of us to presume that we could, through even our most diligent and fervent efforts, totally prevent the concomitant pain, suffering, and confusion that characterize the alcoholic family system. Alcoholism brings pain to any family it touches, a pain that we cannot hope to exorcise completely except by the elimination of the disease itself.

Consequently, it becomes imperative that we direct our energies toward a clearer understanding of the specific stress factors affecting the child in an alcoholic family and, through a concerted program of finely tuned prevention and early intervention techniques, pinpoint the resultant at-risk behavioral and/or attitudinal factors to be addressed. The task set before each of us is Herculean in scope, and the degree to which we focus our energies on specific areas of concern is the degree to which we will succeed in reducing the pain and confusion inherited by these children as a result of their unique place in an equally unique family system.

In this respect, I feel that the current dichotomy that exists between the fields of treatment and prevention is both arbitrary and detrimental to a broader understanding of our task. There is no doubt that practitioners in the field of prevention could learn much from those in the field who are treating such diverse symptomatic issues as truancy, juvenile delinquency, emotional stress, alcohol abuse, and alcoholism among children of alcoholic parents. The potential for analyzing successful treatment strategies in order to determine possible universality and/or causality is very great indeed and could undoubtedly further our comprehension of the evolutionary process that operates within the context of the family.

At that point, discussions of attitudes, self-concept, and peer pressure become grounded in a more sophisticated understanding of causality, and the issues of primary, secondary, and tertiary prevention take on added theoretical and therapeutic significance.

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Rainbow Retreat, Inc.
Phoenix, Arizona

Joanne Rhoads

Introduction

Rainbow Retreat, Inc., opened its doors in 1973 as an emergency "crash-pad" shelter for abused wives and children in alcohol-related abusive situations. The facility was started by Joanne Rhoads with a handful of volunteers, $50, and faith in a higher power. Through Rhoads' efforts, members of the community were made aware of the needs of abused wives and children and became interested in their cause. In June of 1973, Rainbow was incorporated as a private, nonprofit membership organization, with a 21-member board of directors as the governing and policy-making body.

When Rainbow opened on November 1, 1973, it was the first such facility in the State of Arizona, and it is believed to have been the first in the Nation. Initially, Rainbow's capacity was 13 women and children; however, it has since been expanded to accommodate 23. It started by openly publishing its address—anyone in a family who needed help could contact Rainbow Retreat.

It was realized quickly that simple shelter without structured education and therapy was meeting only part of the need, and a comprehensive treatment program was developed. Included were informational lectures, group sessions, and Al-Anon referrals. Outpatient counseling to the alcoholic was also included.

The philosophy of Rainbow has been expanded to permit acceptance of those fleeing any abusive circumstances, rather than limiting services to alcohol-related cases. From Rainbow's humble beginnings, it has grown and matured to meet community needs through diversified programs. From a minimal program of education and group caring, treatment has been expanded to include art and music therapy, job development, relaxation and exercise

therapy, good grooming, legal counseling, assertiveness training, human sexuality, and outpatient and group counseling for all abusers.

Program Description

Rainbow Retreat's programs include the following components:

- Crisis emergency counseling by phone and face to face
- Referrals—both by phone and face to face
- Community education and consultation—both by phone and by speaking engagements
- Crisis residence for women
- Residential treatment for women and children
- Little Peoples Rainbow
- Outpatient—group, one-to-one counseling, marriage and family counseling
- Aftercare
- Lecture series—open to the public
- Day care—where clients can attend treatment programs and go home at night
- Training—of staff, various students/interns from colleges, universities, and other agencies
- Primary prevention—children's program for resident, nonresident, and day-care clients
- Job development included in residential and day-care components

Primary Prevention Component

In July 1977, Rainbow Retreat sought to meet needs in the areas of parenting and children's treatment by implementing the primary prevention program for children. The children served by this program are primarily those who have exhibited no symptoms where undesirable behavior (i.e., abusive drinking) may soon occur, but who have been exposed to behaviors characteristic of alcoholic and other abusive environments. This project intends to address the problems of adverse or negative impacts on young people from environments (primarily home) that are in a state of conflict, severe stress, or crisis brought about by alcohol abuse. Through this program we hope to keep the child's undesirable behavior from appearing and to minimize the risk of alcoholism within the lives of the participants.

The program is implemented through child guidance counselors who work through such groups as T.A. for Tots, rap sessions for

children and parents, art groups, music groups, planned activities, and recreation. We are consulting with a child psychologist who is reviewing prior research literature in this area and is preparing a study designed to test a prevention hypothesis. He is also designing an education program intended to minimize the risk of alcoholism and other abusive behaviors in children.

Described below are behavioral patterns observed in children at Rainbow Retreat that we believe may be characteristic of the high-risk population:

Newborn to Age 3: These children mainly lack physical contact (other than for minimal daily care). They have learned crying and whining as a way to gain attention and were found to have little structure in their lives.

4 to 10 years old: Children of these ages already know how to manipulate both parents. They often feel guilty about their parents' behaviors and even are told in some cases that they and/or their behaviors are the reason for the parents' heavy drinking. They have tried to believe they can change circumstances by acting differently, i.e., "not causing trouble." Because of the unpredictable behavior of the parents, these children are constantly trying to predict what will happen next; thus, they lose the ability to be spontaneous and creative.

11 to 14 years old: These children, along with the confusion present in the disoriented home, are becoming aware of their own sexuality. They have problems in identification of "male" and "female." They often are forced into the position of being responsible for younger children, blamed for problems around the home, and are even made responsible for care of their parents.

15 to 17 years old: Many of these young people already have decided to use alcohol and/or other drugs and are exhibiting problems such as dropping out of school, engaging in violence, and committing juvenile offenses. Some are only "hanging in there" until they can leave the abusive environment.

The major goal of this project is the prevention of alcoholism and the related pain, loss, neglect, and abuse that alcoholism brings to families and, specifically, to children within those families. This is done by:

- Providing shelter to children who accompany their mothers to Rainbow as a result of alcohol abuse within their families
- Providing developmental groups within the community for

the purpose of offering young people experiences in communication, self-expression, and self-understanding.

- Providing support and guidance through one-to-one and group activities to resident and nonresident youths involved in alcoholic environments
- Providing child management groups, one-to-one consultation, and rap sessions at Rainbow Retreat and within the community for the purpose of offering parents guidance, support, and education in effective parenting techniques

Program for Residential, Day-Care, and Drop-In Clients

The individual goal plans used by clients in residence, day-care, and drop-in programs are established by a conference with an assigned child guidance counselor soon after the client arrives at the center. At this time specific crisis needs, long-standing problems, and an enumeration of goals and objectives are discussed, agreed upon, and listed in a treatment plan. The treatment plan is reevaluated, changed, and/or updated with progress notes on each contact with the child and/or parent(s). Weekly goal evaluations are made by noting progress (an expected movement of 20 percent) on the goal attainment scale. At the time of exit, a summary is written with accomplishments, referrals, and recommendations.

- *One-to-One Counseling.* This form of counseling offers children opportunities to share and express feelings, thoughts, and behaviors on a personal level with a caring adult and to interact with an adult without fear of rejection or displeasure.
- *Rap Sessions.* These sessions offer children opportunities to identify and share feelings, thoughts, and behaviors with other children and to discuss a variety of topics, ranging from themselves to the outside world as they see it.
- *Art Activity Group.* Through the use of art and art materials, children may be able to communicate feelings they would not be able to verbalize. Art may be used to help facilitate expression and enhance self-understanding, develop communication skills, and foster personal growth.
- *Story Time Group.* Stories help children relate to character roles, thoughts, feelings, and behaviors. Children are given opportunities to choose alternatives, change outcomes, and discuss their feelings about the stories.
- *Music Activity Group.* Music provides children with a stimulus for emotional expressions, mental images, and physical sensa-

tions. Music can also reduce tension, enhance creativity, and promote a sense of self-satisfaction, freedom, and acceptance of self and others.

- *Structured Play.* Through the use of play and play materials, a child is given the opportunity to express feelings, alternative behavior responses, confusion, and misunderstandings in the presence of an accepting adult without fear of failure or displeasure.

Rainbow's "Little People" Program

Since the inception of Rainbow Retreat women with children have been admitted for services. During this time, we have become experienced in observing the behavior of children from violent family backgrounds. Between May and October 1978, Rainbow Retreat documented 47 admitted cases of child abuse that included physical and/or sexual abuse. In working with these women and children we found a need to offer them more extensive treatment and a greater variety of services. In addition, every month over 200 women with children are referred to other agencies.

Therefore, during early 1979, Rainbow Retreat's services were expanded by 10 beds to provide residential shelter and treatment programs for abused or neglected children. Little Peoples Rainbow, as we have chosen to call it, provides a houselike environment. One unique feature of the program is that we accept a mother and her child into Little Peoples Rainbow even if the mother is under 18 years of age. We believe this to be a positive means of keeping a family together. Our programs are designed to be more than a "stop over" for these children. We estimate that a child who enters our program will continue in an aftercare phase of treatment for 2 years. (It should be noted that since Rainbow is not currently equipped to work with mentally retarded or physically handicapped children, nor with children considered dangerous, these children will not be directly serviced by our programs.)

Little Peoples Rainbow is designed to provide a surrogate family, with the older children acting as "big brothers and sisters" to the younger ones. This family atmosphere provides a less threatening rehabilitation program for all the children. Because abusive family situations tend to produce emotional problems in children, we view our program as preventative, using a positive environment as a model for changing behaviors, attitudes, and values. We teach survival techniques not only to

individual clients, but to the family as a unit. In some circumstances, the mother may be faced with the possibility of keeping her child in foster care indefinitely, or even giving her child up for adoption. Our main goal is to keep the family together as a restructured and functional unit, often with the woman as head of household.

This is a pilot project funded by the Department of Economic Security through the Child Protective Services Department. This program is unique in that it is the first time Child Protective Services has attempted to work with both the mother and child at the same time in a structured setting, rather than removing the child from the mother, and, when the crisis is over (or the child has healed), returning the child to the home setting with no counseling for the parents or child.

We have found alcohol and/or drugs a major factor in our defined child abuse cases. Therefore, our prior behavior observations have been reinforced while working with these clients.

Program Services Description and Staffing

Direct Child Care. The project calls for three well-balanced, nutritious meals per day, plus two snacks. The residential administrator is directly responsible for dietary planning. The housemother plans meals and sees that they are properly prepared in accordance with nutritional standards. The meals are prepared by a cook assigned to the project.

The child care attendant is responsible for working with the child psychologist, counselors, and recreation specialist in providing general and specific care for clients.

Direct supervision comes from the housemother who is responsible for the residential setting. The counselor supervises any aspect of care treatment.

Direct roles of child care staff include supervision of play and activity sessions, assistance in teaching mothers child care, and aid to the child guidance counselor in carrying out the treatment program.

Each child is assigned a counselor when entering our program. This counselor works with the child throughout the child's residence. The same counselor works with the parent, either as the parent's primary counselor or on a consulting basis, depending upon the child's needs. Regardless, the child's counselor attends all staff meetings and is available for all discussions regarding the client's (child) family treatment.

It is the nurse's responsibility to see that special health needs

are met. Followups by the nurse are provided on each child after treatment. If additional health care is needed, the child is referred to a provider of the required medical treatment. The nurse works closely with medical contacts and the child psychologist when any abnormalities or special needs are identified by staff or during personal observation. Proper and complete documentation of events is recorded and monitored.

Activities Offered. Among the activities offered are trips to the zoo, movies, circus, church; sports; art and crafts; Youth Club; Big Brothers and Sisters; pet care; gardening; and entertainment.

Program Planning. When a child is admitted to the facility and a treatment plan is designed, the child's specific needs are evaluated. The goal then becomes a part of the treatment schedule. The responsibility for designing the treatment schedule belongs to the treatment supervisor. The assigned counselor supervises individual planning and participation.

Care Plans. A psychologist tests and/or evaluates the child's needs. All service components are provided to the child by a comprehensive service system capable of analyzing the child's problems. When the client's needs are evaluated and determined, a treatment plan is developed and activities coordinated through the counselor. The housemother and child care attendant assume important roles in ensuring that the programs are being met and activities monitored. Treatment plans are developed for each child as he or she enters the system, in accordance with Joint Commission on Accreditation of Hospitals standards, and evaluated through a goal assessment scale (GAS) system.

Educational Support. As needed, agency staff support any educational needs determined by the specialist or professional providing the service. The Rainbow program has built-in educational aids in the form of educational toys, books, records, and other teaching aids. The child care attendants work with children in furthering their educational growth.

The fact that Rainbow has been able to observe children in residence has been a definite advantage in defining the needs of these young clients. Critiquing their interactions with the mothers and the mothers' with the children, has proven invaluable for intervening in unhealthy behavior patterns. These patterns can be confronted, and alternative ways of handling issues and stress can be offered. While working with all members of a family who are in residence, our staff can predict their behavior

and make them aware of what is happening and what will happen if they continue in the learned interactions they are relying on as their communication tools. This awareness allows the clients to become less personally involved in their parent's alcoholism, to relieve feelings of isolation and rage, and to reduce guilt.

One of our concerns for these children-in-residence is that our agency has no control over when the mother decides to go back to the alcoholic and/or abuser. Another is that when the mother is alcoholic and requires residence care or hospitalization, there is no place to care for the children. We currently are addressing this need and, if funding permits, we should be able to initiate a foster home for children-in-crisis that would allow us to place the child in our own program without the mother going through Child Protective Services.

Community Youth Groups

"Reflections" groups offer young people an opportunity to experience and enhance self-understanding and self-expression, to explore values, risks, and decision makings, to promote social and personal confidence, to understand dependence, and to develop independence and self-responsibility. This is accomplished through the use of games, rap sessions, films, and discussions.

The goal is to provide eight ongoing groups in the community of 6, 8 or 10 weeks' duration, with a minimum of five young people per group. Although the community youth groups and the child management groups may be 6-, 8-, or 10-week sessions, with evaluations at the end of each set of sessions, they are continuous and ongoing, as are the residential and nonresidential programs.

Most literature related to substance abuse prevention and its definition includes as major strategies early identification and intervention, education, and personal skills development. From the beginning of this project these major strategies were considered and integrated into the total program.

There need not be an alcoholic involvement in order for a young person to attend a group.

The groups provide the following:

- Structured informational and educational programs to teach life survival techniques to young people
- Educational and direct counseling to programs in the community, the employment training field, and other conventional institutions
- Redirecting and motivating positive attitudes, behaviors, and skills through counseling of the youths contacted

- Developmental groups within the community for the purpose of offering experiences in communication, self-expression, and self-understanding
- Child management groups, one-to-one consultation, and rap sessions at Rainbow Retreat and within the community for the purpose of offering parents guidance, support, and education in effective parenting techniques

In our outreach program "Reflections," we decided to concentrate on places in the community where young people went to socialize, i.e., clubs, organizations, and churches, rather than the schools. We have found this to be helpful in our initial contacts. We do not have the added resistance encountered in contacting young people in a required setting such as a school or detention home. Trust level is easier to establish in these groups.

Because of the nature of the program, it is difficult to involve parents. We have not been able to devise a method that will mandate a parent into treatment when necessary.

Assessment of Program Experience

A. *Areas in Need of Improvement*

Over the last 6 years it has become more apparent that a good data base and proper evaluation are not only necessary but indispensable to a sound planning process. Rainbow has learned this lesson from the school of hard knocks and now requires any new program to include an evaluation base prior to implementation. Evaluation is, without a doubt, one of the most important needs of a new or continuing program. In concert with evaluation, the data base must be tested periodically to ensure that usable information is being collected. Without this information it is difficult to ascertain the reasons for program success and/or failure.

Listed below are factors that should be included in program/client evaluation and design:

- *For Program*
  - —Quantify established goals and objectives
  - —Establish quantified goal/objective relationships
  - —Develop evaluation measures
  - —Develop data needs
  - —Determine methods of analysis
- *For Clients*
  - —Develop pre- and postinventories/questionnaires of parent/child

—Followup inquiry/questionnaire
—Furnish data-gathering techniques
—Assess client gains
—Develop client feedback forms
—Develop assessment scale
—Perform aftercare evaluation (followup)

Rainbow Retreat has learned many lessons, both positive and negative, during the years of its development. Our program continues to change and expand in response to new demands of society and ever-changing client needs. Listed below are additional areas where our agency has observed the need for review and improvement. Although some "needs" include an addressed alternative or solution, others are not addressed because they currently do not have a realistic solution; some remain in the planning/evaluation cycle.

B. *Program Needs/Alternatives*

General Prevention and Education Activities:

- The need to provide educational and developmental resources to young people, ages 4 to 17, who are involved in alcoholic and other drug-related or abused environments
- The need to more systematically educate youths about the disease of alcoholism and drug dependency
- The need to provide young people with group activities that may explore alcoholism, family problems, peer pressures, and sexual attitudes
- Solutions/Alternatives:
  —Statewide conferences on child abuse and alcohol
  —High school and junior high school seminars and forums
  —Speakers' bureaus on child abuse and alcoholism
  —Community consciousness-raising workshops on drinking attitudes and practices

Program Expansion/Revision:

- The need to develop skills in self-expression
- The need to establish exercises focusing on better understanding of self
- The need to provide exercises to explore problems encountered in values, risks, and decision making
- The need to provide added sources of social support and personal encouragement
- Solutions/Alternatives:
  —Establishing advanced programs to deal with strong emotions: fear, loneliness, rejection, etc.

—Use of videotape as a program aid for role-playing therapy

Community Mechanisms:

- The need to increase public relations/advertising to promote outpatient services of Rainbow
- The need to solicit cooperation and input from community resources in the design and development of impact literature
- The need to solicit cooperation of advertising and mass media personnel to develop promotional strategies
- Solutions/Alternatives:
  - —Use of community magazine for feature stories
  - —Greater use of newspapers, editorials, etc. about abuse and alcoholism
  - —Solicitation of agencies to assist in public relations campaign

Staff Development:

- The need to increase staff training from 30 hours per year to 50 hours per year
- The need to provide direction and administrative support to Rainbow staff in their efforts to increase the proficiency of treatment, care, and support to residential clients
- The need to develop "educational/training" incentive plans for employees that include monetary compensation
- The need to increase training "trade-off" with like agencies and to share treatment techniques and concerns via affiliation agreements
- Solutions/Alternatives:
  - —Seek outside training classes that are low in cost or free
  - —Use other community agencies through affiliation agreements
  - —Develop greater administrative planning skills to insure that maximum time is allocated to program review and design

Third-Party Payment:

- The need to design and implement a more exacting method to judge client's ability to pay
- The need to develop quality assurance standards to facilitate third-party payments
- The need to improve the experience and skill of staff to collect third-party payments
- Solutions/Alternatives:
  - —Develop closer liaison with insurance companies to insure that the program is understood and that the overall benefit to the companies is reported

Miscellaneous Areas:

- The need to design a need-assessment survey for dissemination to social service agencies for evaluation upgrading
- The need for increased in-house program to clients
- The need to increase legal aid service contacts
- The need to provide more assistance in the planning and conservation of new programs and methodologies for domestic violence and alcoholic situations
- The need to use volunteers to develop programs where paid staff are an impossibility
- The need to use volunteers to consult attorneys in the community and ask them to donate their time as a group
- The need to develop more comprehensive counseling programs throughout the social service agencies

Advocates Needs:

- The need to have ongoing data collection on a national level
- The need to develop a close liaison relationship with key legislators and legislative staff members
- The need to develop capabilities for effective grass roots lobbying, including letter writing, media exposure, etc.

Key Issues for Discussion

A. *Prevention*

The need to improve public awareness by expanding and improving media-oriented prevention program

The need to promote the development, printing, and distribution of literature as a nationally sponsored consultation educational program, relating to various social and health problems associated with the misuse of alcohol

The need to develop, review, and evaluate new programs and to disseminate new and existing knowledge on the causes and consequences of alcohol use and related problems

The need to increase community knowledge of treatment resources and local/statewide programs and develop a strategy to reduce alcohol-related problems through improved public relations programs

B. *Identification and Intervention*

The need to increase the involvement of the family (as a primary unit) in the early intervention and prevention of alcohol-related problems

The need to prepare an informational packet for families to use as a tool for understanding alcoholism

The need to increase the role of law enforcement in the "non-enforcement" role of child protection and crisis intervention

The need to educate both the battered (no matter who or how old) and the assailant about their legal rights and responsibilities and to identify early drinking problems

The need to increase the skills and knowledge of program personnel through training in alcohol-related problems and in techniques of treatment and identification through cooperation with State programs

The need to formulate nationally accepted program evaluation scales and client outcome evaluation forms to gather more concise, compatible, and testable data to provide information that would be instrumental in formulating new programs and treatment models

C. *Treatment*

The need to evaluate and institute more programs designed to reduce violence situations, which in many cases are directly related to the abuse of alcohol and the need to address methods of development and funding for these programs

The need for methods to build monetary responsibility into the treatment plans for all adult clients and, if the primary client is the child, the need to contact the parent or parents and make them aware of the monetary responsibility that is being incurred

The need to increase family involvement in counseling sessions through treatment goal assignment

The need to increase program self-sufficiency by expanding outpatient and payment programs

The need to open additional channels with community agencies involved with this problem and to develop a supportive, nonduplicative system for referral and treatment

Kolmac Clinic
Silver Spring, Maryland

Tarpley M. Richards, LCSW

Introduction

Services to children of alcoholic parents began at the Kolmac Clinic in 1976 in response to the changing needs of our treatment population. By that year at least one-third of the alcoholic patients in our clinic were aged 40 or below, and the majority of the younger patients who were or who had been married had children between the ages of infancy and 18. Since family participation has always been a part of the Kolmac alcoholism program, an increasing number of patients began to appear with young children in tow.

For about a year, the staff who were responsible for organizing family member participation experimented with seeing children in family sessions, didactic presentations, spontaneous children's groups, and family therapy. Children who were identified as "problems" by parents or by the staff were evaluated and given treatment in their own right. Many of the children who accompanied their parents to the clinic did not manifest problem behavior. However, the staff still believed these children needed attention, at least to the extent of education that might bring to the surface covert difficulties. This staff belief led to the development of a special children's program.

For 2 years the primary prevention service for young children was offered as an extra, above and beyond the scope of treatment services for disturbed children and alcoholic and psychiatric patients. The prevention service was provided at additional cost because we had not yet discovered a way to support financially such an undertaking.

From 1976 to 1978 our most concentrated focus in service delivery to children of alcoholic parents was to those who were

seriously impaired. These children were for the most part between the ages of 12 and 16. Our approach was child-centered: The child was seen in individual therapy with adjunctive family therapy. The prevention program, meanwhile, limped along, being organized at those times when there were enough parents willing to invest additional funds for children who weren't "sick."

After 2 years the staff became convinced that instituting a prevention program was essential. We had sufficient evidence that the children being treated had not always been so troubled; in fact, all of them had been reasonably functional until the seventh grade. We believed that had intervention taken place earlier in these children's lives, the course of their difficulties might have been altered significantly. This thinking led to the inclusion of a prevention program in the mainstream of the day-hospital program. We were sufficiently committed to the idea of early education/treatment to prevent later adolescent disturbances, and possibly alcoholism in later life, that the day hospital effected a modest increase in the daily facility fee. As a result, every day-hospital patient now contributes to the support of our prevention program for children.

Population Served

Kolmac Clinic is a private psychiatric and alcoholism day hospital and outpatient facility accredited by the Joint Commission on Accreditation of Hospitals. It is located in the medical district of Silver Spring, Md., a middle-class suburb of Washington, D.C., 2 miles south of the beltway; thus, the clinic is within a reasonable commute for most residents of the Washington metropolitan area.

Patients are referred primarily from Federal employee-assistance programs, physicians, the Montgomery County Public School System, and the detoxification unit of the Washington Adventist Hospital. Hence, alcoholic patients served are, in the broadest sense, "middle-class": They are employed and have health insurance that covers a substantial portion of the cost of treatment. Children who are referred for services at Kolmac are the offspring of this middle-class clientele.

Program Description

A. *Services for Children and Staffing*

The following services and staff are available to children who are referred to the Kolmac Clinic:

- Initial inquiry, information, identification of the problem, and referral to the appropriate staff therapist are handled by Nancy Anderson.
- Psychiatric evaluation and medical supervision, if needed, are provided by George Kolodner, M.D.
- Didactic alcohol education for adults and children over age 14 is scheduled Monday–Friday from 7 to 8 p.m. for 6 weeks, under the direction of James McMahon.
- A six-session program of alcohol education for children ages 6 to 14 is conducted by Tarpley Richards, LCSW, and Nadine Alemian.
- Individual psychotherapy with conjoint family sessions is provided by Tarpley Richards, LCSW, and Linda Shepard, LCSW.
- Family therapy is provided by Tarpley Richards, LCSW, and Linda Shepard, LCSW.
- Day hospitalization is available for disturbed adolescents over age 16, under the management of Mary Anne Annis, R.N.

B. *Description of Children's Alcohol-Education Program*

The Kolmac Clinic provides a 2-hour weekly program of alcohol education based on the model of activity groups for children ages 6 to 14. Children of clinic patients are eligible to attend this program for as long as their parents are in the intensive day-hospital program, or for 6 weeks, or as determined by the staff. Prior to a child's entry into the program, a brief meeting with the child's parent(s) is held by the staff of the children's program to establish a contract. The contract is simple: The parents must agree that once their child has entered the program, the child will attend regularly for a minimum of 4 weeks.

The children's program is held every Friday from 6 to 8 p.m. During the first half-hour children and staff meet informally to orient new children to the clinic and to share food. The "food" is brought by the children and prepared as a group effort. It is simple and nutritious: grapes, cheese, peanut butter, carrots, apples, crackers, etc. The purposes of this food-sharing are to enable children to interact quickly and to build group cohesion.

From 6:30 to 8:00 p.m. a structured program is provided. In addition to factual learning, the controlled and focused activity group helps the children to have a release of affect and to undergo a corrective emotional experience. The techniques of the therapist involve identification, imparting information, interpretation, and reassurance. The task of the group is to expand the

ego strength of the children and to add to the children's repertoire of coping mechanisms. The program provides:

- Staff knowledgeable about alcoholism, child development, and pathology
- Materials selected for this age group
- Activities appropriate for learning the necessary facts about alcohol and alcoholism
- Peers—a range of children placed in groups in order to maximize the learning experience

The purposes of the alcohol-education program for children are as follows:

- To learn from the children what they already know about alcohol use and alcoholism
- To take the children through a corrective or additive learning experience regarding alcohol use and alcoholism
- To give the children a place to express their feelings about experiences living with an alcoholic parent
- To give the staff an opportunity to detect disturbances in the children that could lead to the recommendation of further diagnostic work and/or treatment

Examples of group lesson plans are as follows:

- Movie "To Your Health" (Spears Communications International, Inc., Arlington, Va., 1956) followed by individual art assignment. Instructions: Demonstrate on paper anything new you learned in the movie.
- Book, "Alcohol: What It Is and What It Does," followed by individual art assignment. Instructions: Show on paper what you liked best about the book.
- Individual art project. Instructions: Illustrate three wishes you have about the alcoholic situation in your home.
- Group project on large sheet of paper. Instructions: Create a story about alcoholism and what happens.
- Individual art project. Instructions: Create sentences and questions using 100 cue cards. Cards have affective words about person, in family relationships, and alcohol-usage words.
- Individual art project. Instructions: Write a story with a moral. Each child writes a fable about alcohol use and what happens.

Assessment of Program Experience

A. *Program Success*

We believe that the success of Kolmac's services to children of alcoholic parents is the result of a treatment philosophy em-

ploying day hospitalization. This philosophy overcomes what we regard to be major obstacles in service delivery to this population. These obstacles are resistance of parents, lack of referrals sufficient to support the staff available to provide services, lack of funding for a prevention program, and lack of cooperation between the parent's therapist and the child's therapist. Each of these is discussed below.

Resistance of Parents. The staff's earliest problem was with intervention. Our initial experience was that alcoholic patients wished to protect their children from treatment on the grounds that the children were either too young to know what was going on or were mute, indicating that everything was okay. Three years ago we had more strike-outs than hits. Parents were indefatigable in creating excuses for why their children couldn't come. During the year since the primary prevention program became a part of the day hospital and the staff made it clear at intake that children were expected every Friday, we have been effective in getting children in. Staff expectation and the fact that the children's education program is held at a time when patients and adult family members are scheduled to come to the clinic for either group therapy or didactic lectures have been highly effective in combating parent resistance.

Referrals. When an alcoholic person is referred to treatment at Kolmac, his or her children are referred by inference. It is our policy to assess the functioning of the entire family; any member of the family who is experiencing difficulty is offered services at Kolmac. Our experience to date indicates that "nonproblem" 6- to 14-year-old children of alcoholic parents would not have been referred otherwise, because they have not been identified elsewhere as children in need of services, i.e., by the school, truant officers, court, etc. Generally, "problem" children who are seen at the clinic are parent referred.

The referral load is fairly constant and predictable; we can sift through 4 years of clinic growth data to determine about how many children to expect in a given month. This predictability precludes overstaffing or understaffing and keeps morale at a steadily high level.

Funding. Another early barrier to providing services to children was money. Before the children's alcohol-education program was incorporated into the day hospital, this service for children was offered at extra cost. Parents, already feeling burdened by

the cost of the alcoholic's treatment, were highly reluctant to part with even more money to help a child who wasn't "sick." The program of alcohol education has now been financed by effecting a modest increase in the daily patient facility fee. Hence, if parents seem at all hesitant about bringing in their children for education sessions, they are told that they have already paid for them.

Funding for psychotherapy for disturbed children of alcoholic parents is managed through third-party carriers. The two staff members who provide most of the therapy for children are licensed, certified social workers in Maryland and are eligible for third-party reimbursement by any major medical insurance sold by a company in the State of Maryland.

Cooperation Between Parent's Therapist and Child's Therapist. In general, the approach to treating children at Kolmac is child centered, but parents are always included in conjoint sessions with the child because therapy for the parents is considered essential. The timing of intervention with the child seems to us to be of paramount importance. Children usually are referred when the family is in crisis, and this usually means the involvement of alcoholism counselors, nurses, social workers, schools, employers, and physicians. The day hosptial affords crisis management, detoxification, alcoholism treatment, psychiatric treatment, family member therapy, patient education (in any order), and long-term aftercare treatment. These sessions are available within a flexible time frame and are conducted under one roof. Staff can meet daily to transmit information and hold twice weekly formal staff meetings for treatment planning and coordination.

The following example illustrates how a child of an alcoholic parent was saved through timely intervention and a high level of staff cooperation:

- The mother of a 12-year-old boy was referred to Kolmac for alcoholism treatment. The mother entered the intensive treatment phase, and the father attended about five family sessions. The mother was concerned about her 12-year-old son's difficulties in school. The school had offered services to the boy a year earlier, but this effort was undermined by both parents. The mother formed an attachment to the clinic staff, but the father dropped out of treatment.

  After 6 months of sobriety and treatment the mother requested that her son be seen for evaluation. This request was honored. The boy indeed needed therapy. He was seen for about

5 months, at the end of which time the mother made a decision to leave the father. Because she felt that this change was all the boy really needed, she withdrew him from therapy. The mother's therapist and the boy's therapist agreed that to push the mother at that time would be fruitless. The mother's therapist continued to work with the mother and helped the mother work through her faulty perception that getting away from the father would be a cure-all for the child. After 4 months the mother agreed to return the boy to treatment, having realized that his problems were not yet solved.

B. *Needed Improvments*

The following are lacking in Kolmac's effort to provide services to children of alcoholic parents: a reliable evaluation instrument, a means to reach children whose alcoholic parents are not Kolmac patients, and a primary prevention program for children aged 14 to 18. Each of these is discussed below.

Evaluation. Evaluation of our work with children is not objective in a scientific sense. We rely on staff observation and child and parent self-report. We need to become familiar with a more reliable evaluation method.

Reaching Children Whose Alcoholic Parent Is Not a Kolmac Patient. For the first 2 years that the Kolmac Clinic offered services to children of alcoholic parents, Tarpley Richards spent a great deal of time in outreach, but with meager results. Outreach consisted of conducting workshops on children of alcoholic parents for organizations such as the Washington Area Council on Alcohol and Drug Abuse (the local National Council on Alcoholism affiliate), the Maryland Institute of Alcohol Studies, and professional organizations such as SELF (social workers employed less than full time). Many professionals in the field of child care attended those sessions and appeared interested to know that these services were available, but none of the attendees has referred a child for treatment.

In addition, Richards spoke with child detention center staff, day-care center staff, public school counselors, PTA's, and county judges. Still no referrals resulted. Other alcoholism treatment centers in the Washington, D.C., area also have been informed of the availability of Kolmac services to children, but again there have been no referrals.

We need to learn how we might be more effective in attracting

referrals of children by other child mental health personnel and alcoholism treatment centers that do not provide services to children.

Primary Prevention Programs for Children Aged 14 to 18. We have not been successful in attracting "nonproblem" middle-stage adolescents to alcohol-education sessions at the clinic. Parents of children in this age group complain they can't get their children to come in: the children work, or have pressing social activities, or have too much homework, etc.

Paradoxically, our most accomplished and concentrated effort in work with children of alcoholic parents has been with this same age group. But the children that we do see are in for secondary prevention at best. These 14- to 18-year-olds are already in deep trouble: failure in school, truancy, isolation from peers, and their own alcohol/drug abuse.

We need to learn how we can intervene with this age group before serious problems erupt.

Key Issues for Discussion

We would like to discuss the following issues at the symposium on services to children of alcoholic parents: policy, identification and intervention, interagency cooperation, funding, evaluation, and treatment.

Policy. In order for services to children of alcoholic parents to gain national momentum, it appears to us essential that NIAAA have a policy that states that grantees and contractors who receive Federal financial assistance in establishing alcoholism treatment services be required to provide a spectrum of services to children of alcoholic parents or to refer children to recognized agencies in the community who already provide these services.

Identification and Intervention. Children of alcoholic parents can be identified by a number of public and private sources, e.g., school counselors, clergy, child protective services, physicians, family service agencies, alcoholism treatment centers, the court system, etc. The issue is, once children have been identified, how does not intervene on their behalf? What are the specific steps in the intervention process?

Interagency Cooperation. In sharing its expertise, how can the field of alcoholism treatment reward other agencies and/or persons for cooperation? (Kolmac's experience has been that in many instances agencies and individual health-care providers

are reluctant to refer because often they simply "lose" a patient.)

Funding. What are the advantages and disadvantages of funding services to children of alcoholic parents through Federal grants and contracts? Through State and local governments? Through the private sector?

Evaluation. Is there a reliable instrument available that can be adapted or modified for use in evaluation of the efficacy of various services to children of alcoholic parents?

Treatment. Specifically, what needs of children of alcoholic parents are to be "treated"? What can alcoholism professionals provide that will complement those services other providers are already offering?

The Educational Aspects of Servicing the Children of Alcoholics

Janet G. Woititz, Ed.D.

I offer courses in counseling, communication skills, and personal values at Montclair State College as well as a course in counseling children of alcoholics at Rutgers Summer School for Alcohol Studies. I have a private practice specializing in families affected by alcoholism, with particular emphasis on the affected children. I conduct workshops, consult, and publish. I work cooperatively with schools, other mental health professionals, the legal profession, and the self-referrals who appear at my door. Since I do not represent anyone other than myself, I can only discuss my own growth over the last 10 years, and how I see its development. All this is both explanation and apology for the first-person narrative of this paper.

I have chosen to remain in the mainstream and specialize because doing so affords me a platform to reach, influence, and intervene with—as an insider—a population that might otherwise be inaccessible to me. I have the opportunity to be aware of the whole range of children of alcoholics—from the profoundly disturbed to the emotionally sound. Since I am essentially a teacher, I would like to discuss the educational aspects of servicing children of alcoholics. I see many of the issues that need to be confronted in helping the children of alcoholics as primarily educational ones. Some of these issues need to be addressed in a traditional educational sense and others in a more innovative mode.

Population Served

The population I serve is quite varied. I receive referrals from the court, from schools, and from involved parents. But the bulk of my population is self-referred and self-identified. Where young children are involved, I usually work with the parent(s) and have someone else see the child. I personally see those who are adolescent and older.

The intervention that arises from self-identification is usually achieved as the result of information received from me in either a class or lecture setting. There is rarely a day that passes when a student is not sitting outside my office door waiting to talk to me about the discovery that his or her pain and home life are not unique.

Program Description—Philosophy and Treatment

I have found that most of the process for the specialist in working with the children of alcoholics is an educational one. When the issues involved deal with living with alcoholism and the resulting suffering, the specialist is important. When these issues are resolved, what is left—if there are problem areas left—can be handled by a supporting agency. It is important to recognize that those of us who specialize in this area cannot do it alone Alcoholism is a problem of epidemic proportions, and working cooperatively with all the supportive services available to us is the only way to make a difference. We need deal here only with those aspects that relate to alcoholism. It is not possible to discuss all of them.

I think these children tend to be looked upon as tragic figures and that sometimes this is a mistake. Many of them are helped easily and dramatically in relatively short periods of time. Though the problem is broad and varied, often it is more important to recognize the urgency of early intervention than it is to survey the damage. This is especially true because children of alcoholics cannot be defined in terms of age. Without some kind of intervention, they will tend to preserve unhealthy self-attitudes, and in later life, repeat the same patterns with their own families.

It is necessary to look at the simpler levels first and work from there. Because children of alcoholics do not necessarily perceive themselves to be unloved, a large percentage of them do not suffer the ravages of outright rejection by parents but rather "bounce off the walls" because of the behavioral inconsistencies. This is a

far more manageable situation for the clinician when trying to turn a child around.

The alcohol-education programs in our schools do a relatively good job of pointing out what will happen to you if you drink irresponsibly. They do not do any job at all, as far as I can see, in pointing out what will happen to you if your parents drink irresponsibly. Just as we can find patterns of behavior in alcohol abusers, we also find patterns of behavior in those who are abused by the alcohol abuser. In my own classes, I have found that imparting this kind of information is very helpful in reducing the burden of guilt on those children. If they see themselves described in a way that doesn't threaten them, they can begin to understand their situation and to seek help. We can pick them up earlier this way and have less of a struggle with the syndrome of denial. I have had many students tell me that until they heard me speak, they were not aware that they were living with alcoholism but *were* aware that something was terribly wrong. They couldn't ask for help because they didn't know what to ask help for. I strongly encourage anyone working in the schools to include this aspect of the problem in their alcohol-education curriculum.

The first step in treatment involves changing reactive patterns and inducing a movement from external to internal locus of control. This, too, is largely educational. The child from an alcoholic home suffers in four main areas: self-concept, peer relationships, home life, and school life.

Attitudes about home are usually ambivalent. Although they are unhappy at home, they feel needed. Although they are angry with the alcoholic or the irritable nonalcoholic, they feel responsible. They hunger for the love of the rejecting parent and are bound to this parent emotionally. There is a feeling of guilt; children feel that if they were better people their parents wouldn't drink. They also feel that there must be something they can do to get their parents to stop drinking.

These attitudes are supported by the alcoholic who does not want to take responsibility for his or her behavior. It has been my experience that the college students I see who come from alcoholic homes need to be taught that their primary responsibility is to themselves. If the father is the alcoholic, the ties are primarily emotional; if the mother, not only are there emotional ties, but chances are that from a very early age the child has had considerable responsibility for running the house.

Children suffer in the area of social relations as well. They are

afraid to establish friendships because they are embarrased to invite their friends home. They don't know what will happen or how their friends will be treated when they arrive. Since they cannot explain this ahead of time and since eventually invitations from others must be reciprocated, many withdraw or act out in such a manner as to be rejected by others. One also cannot lose sight of the fact that the child who has been taking over adult responsibilities at home or has withdrawn does not learn how to interact with peers. This child does not know how to establish friendships or even to play.

This is an educational problem. Although it is not too difficult for children to understand that broadening their social spectrum is beneficial, the counselor or the teacher must literally teach them to do this. They must be taught how to make friends and how to be children. In adolescence, many of these chilren have difficulty relating positively to dating. It may be necessary to go through the "whole date" in order for the child to understand what went wrong. The girl who has only heard her mother speak in castrating ways to her alcoholic husband will tend to pattern herself after the only model she knows. This is not necessarily a symptom of a deep, underlying psychological problem; it can be simply a how-to issue. Promiscuous behavior with these children also can be a simple matter of not having been taught there were choices available to them. What is seen as a symptom is quite often simple ignorance.

School performance and attitude suffer as well. These children either do very poorly or they overcompensate. It is hard for children to develop a good attention span or to concentrate on school work when they are concerned about what is going on at home or if they've been kept up most of the night by an alcholic parent. The model child more often than not will develop physical symptoms and will fall apart at a later stage. The child working below potential can be taught healthy ways to compensate and to deal with stress. Once absolved of guilt for the family atmosphere, the child can be taught ways to increase concentration. Tutoring, a healthy role model, and understanding of the alcoholic family system can provide enormous support for these children.

The educational aspects that I consider so critical, teaching the child how to play, how to relate to other children, how to manage stress, and teaching the older child how to socialize, are important to normal development and all that it implies. They are important to health in the alcoholic household, but their sig-

nificance should not be underestimated in the family system when the chemically dependent member gets sober and wants to become a fully functioning member of the family. This is an aspect that concerns me greatly and that I would like to have aired at this symposium.

The child who has assumed the stereotypical "adult role" is defined by that role. When the parent returns to the family system and wants to pick up the roles that were abandoned, the child loses part of his or her identity and has no substitute. To tell the child that you will prepare the meal and that he or she should go out and play is unfair to the child who does not know how to play. The child now feels displaced and irrelevant. The focus in the rebuilding of the family unit cannot be based primarily on the needs of the alcoholic if the system is to become healthy. Sometimes the needs may seem contradictory, and unless careful attention is paid to what sobriety means to the child, a whole new set of problems will emerge. These, I believe, are preventable if the perspective of both the child and the parents is taken into account.

The difficulties in building a healthy self-image are obvious. The difference that I found in my research with children from alcoholic homes and those in a control group lay in a distorted perception of reality. Confusion as to who one is is part of the developmental process, but these youngsters lose a sense of truth. Lying is a way of life and, not unlike their parents, they often are not aware that they are lying. My concern is not so much for the lying as for the lack of awareness. Choice does not exist unless there is awareness. Intelligent choices require education.

The aspect of prevention also can be looked at largely in educational terms. Children need to be taught from a very early age to make decisions. The process is a learned one, and they need to be taught to take responsibility for their behavior. They also need to be taught to develop a value system so that they can think about their world and its meaning to them. These tools, and the education specific to the chemical itself, will help afford youngsters a choice. Children will experiment, whether adults like it or not; it is part of growing up and cannot be denied. However, they can learn that they have choices and that the exercise of these choices can mean fewer children will be caught either in a chemical or emotional bind and, that those who do, can find ways out.

We are ill-equipped to be parents under the best of circumstances. The circumstances of living with alcoholism are espe-

cially difficult. I have spoken to many parents who, although they cannot accept the fact that alcoholism is a disease, are scared to death that their children will inherit it. Teaching parents how to parent can take some of the pressure off them. Parents can be a great aid in prevention. I encourage any setting that involves children also to involve parents—and vice versa. The first is usually true; the second, rarely. We need to focus more on this aspect of family treatment. Although no one is unaffected by the alcoholic home, the sooner we identify the victims, the better chance we have to reduce the suffering. To do this, we must reach the mainstream. And the most effective way to reach the mainstream is through education.

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